NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Robert Mack

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Friday 21 January 2011 10:00 a.m.
Committee Room 2, Haringey Civic Centre, High Road, Wood Green, N22 8LE

Councillors: Maureen Braun and Alison Cornelius (L.B.Barnet), Peter Brayshaw and John Bryant (L.B.Camden), Christine Hamilton and Mike Rye (L.B.Enfield), Gideon Bull (Chair) and Dave Winskill (L.B.Haringey), Kate Groucutt and Martin Klute (L.B.Islington),

Support Officers: Sue Cripps, Katie McDonald, Robert Mack, Pete Moore and Jeremy Williams

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. URGENT BUSINESS

3. DECLARATIONS OF INTEREST (PAGES 1 - 2)

Members of the Committee are invited to identify any personal or prejudicial interests relevant to items on the agenda. A definition of personal and prejudicial interests is attached.

4. MINUTES (PAGES 3 - 10)

5. VASCULAR SURGERY (PAGES 11 - 104)

To update the JHOSC on work being undertaken by the NHS in North Central London in response to the recently published Cardiovascular Strategy for London.

6. QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION - COMMISSIONING PLANS FOR 2011/12 (PAGES 105 - 106)

To receive an overview of commissioning plans that have been developed across the NHS in North Central London.

7. UPDATE ON THE MENTAL HEALTH WORK PROGRAMME (PAGES 107 - 108)

To update the JHOSC on work being undertaken across the sector to develop mental health services.

8. LOW PRIORITY TREATMENTS (PAGES 109 - 150)

To consider the extension of the policy for low priority treatments for North Central London PCTs.

9. NCL UPDATE (PAGES 151 - 152)

To report on progress with the NHS North Central London work plan, including:

- Management costs
- Financial position
- Progress of transition to GP commissioning
- BEH Clinical Strategy

10. NEW ITEMS OF URGENT BUSINESS

11. DATE AND VENUE OF NEXT MEETING

To agree a date and venue for the next meeting of the joint committee.

Agenda Item 3

DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF

What matters are being discussed at the meeting?

Do any relate to my interests whether already registered or not?

NO → You can participate in the meeting and vote

YES

Personal interest

Is a particular matter close to me?

Does it affect:

- me or my partner;
- my relatives or their partners;
- my friends or close associates;
- either me, my family or close associates:
  - job and business;
  - employers, firms you or they are a partner of and companies you or they are a Director of
  - or them to any position;
  - corporate bodies in which you or they have a shareholding of more than £25,000 (nominal value);
- my entries in the register of interests

more than it would affect the majority of people in the ward affected by the decision, or in the authority's area or constituency?

NO

NO

YES

You may have a **personal interest**

Declare your personal interest in the matter. You can remain in meeting, speak and vote unless the interest is also prejudicial; or
If your interest arises solely from your membership of, or position of control or management on any other public body or body to which you were nominated by the authority e.g. Governing Body, ALMO, you only need declare your personal interest if and when you speak on the matter, again providing it is not prejudicial.

Prejudicial interest

Does the matter affect your financial interests or relate to a licensing, planning or other regulatory matter; and
Would a member of the public (knowing the relevant facts) reasonably think that your personal interest was so significant that it would prejudice your judgement of public interest?

YES

You may have a **prejudicial interest**

YES

Do the public have speaking rights at the meeting?

YES

You should declare the interest but can remain in the meeting to speak. Once you have finished speaking (or the meeting decides you have finished - if earlier) you must withdraw from the meeting by leaving the room.

NO

You should declare the interest and withdraw from the meeting by leaving the room. You cannot speak or vote on the matter and must not seek to improperly influence the decision.

Note: If in any doubt about a potential interest, members are asked to seek advice from Democratic Services in advance of the meeting.

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NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Joint Health Scrutiny Committee held on 19 November 2010 at Enfield Civic Centre, Silver Street, Enfield, Middlesex EN1 3XA

Present: Councillors: Alison Cormelius (LB Barnet), Peter Brayshaw and John Bryant (LB Camden), Christine Hamilton and Mike Rye (LB Enfield) Gideon Bull and Dave Winskill (LB Haringey) Kate Groucutt and Martin Klute (LB Islington)

Officers: Mike Ahuja and Andy Ellis (Enfield), Katie McDonald (Camden), Robert Mack and Carolyn Banks (Haringey), Pete Moore (Islington) and Jeremy Williams (Barnet)

1. WELCOME AND APOLOGIES FOR ABSENCE

Mike Ahuja welcomed everyone to the meeting and to Enfield's Civic Centre.

2. APPOINTMENT OF CHAIR AND VICE CHAIR

RESOLVED:

That Councillor Bull be appointed Chair for the life of this Joint Committee and Councillor Bryant be appointed Vice- Chair.

3. URGENT BUSINESS

There was none.

4. DECLARATION OF INTEREST

The following declarations were made:

Councillor Cornelius - Chaplaincy at Chase Farm hospital
Councillors Groucutt and Brayshaw - Governors at UCH
Councillor Bull - employee at Moorfields Eye hospital

5. TERMS OF REFERENCE AND PROCEDURAL ARRANGEMENTS

Further to previous meetings it had been agreed that this body had a role in responding to any sector wide proposals for changes to specialist services and that it would take a strategic role in scrutinising sector wide issues through regular engagement with the NHS North Central London. This engagement was particularly important as NHS North Central London was to be the transitionary body for the switch to GP led commissioning. It

was noted that the amended terms of reference were currently being confirmed by all boroughs.

There was some discussion around the quorum and it was agreed that it should be one from at least four of the participating boroughs. This would ensure that it would not be possible for the absence of one authority to prevent the Committee from functioning. Although it was hoped that a consensus would be achieved, the procedures would allow for minority reporting in the event of their being irreconcilable differences of opinion. However, it was recognised that this would detract significantly from the influence of the Committee. Since the recommendations and reports should reflect the views of all Authorities the meeting agreed that there should be one vote per Authority.

The meeting was of the view that the NHS North Central London should be asked to fund a post to provide support to the JHOSC. It was accepted that this body would become the key strategic health scrutiny body for participating boroughs. Clarification as to what the post would entail would need to be provided.

It was agreed that, for future meetings there should be a standing item from all boroughs on local health issues. Also the next meeting should consider a financial report on PCT's, progress on GP commissioning and on the setting up of Well Being boards.

RESOLVED:

1. That the terms of reference be agreed.
2. That the quorum be one from at least four of the participating boroughs
3. That in view of the need for recommendations and reports to reflect the views of all authorities there be one vote per authority.
4. That the NHS North Central London be requested to consider the provision of funding for one post for 2011/12 to provide policy and research support to the Committee.
5. That there be a standing item for future meetings on health issues in each borough.
6. That the next meeting receive reports on:-
    - Financial matters relating to PCT's
    - Progress on GP Commissioning
    - Progress on setting up of Well being boards

6. NHS NORTH CENTRAL FUTURE PLANNING 2011/12

The meeting received a presentation from Martin Machray, Assistant Director of Communications and Engagement, NHS Islington on future planning and challenges facing the health system over the coming years. The report, whilst it set out the context of health care and provision across the area, did not produce solutions. The NHS had to produce short and medium term plans on how to meet the challenges and consider how best

to engage with members and the public. Details of the challenges and priority clinical areas that lay ahead were described. It was noted that provision had to be made to address the challenges without any major reconfiguration and with a cut in funding in real terms, by 2014/15 in North Central area there could be a cumulative commissioning deficit of £591m, and this was not sustainable.

One of the key challenges was to ensure that up to date population data was being used. The Committee were concerned that official population figures were an underestimate of the actual position. It was proposed that the boroughs pool their own figures with the NHS and offer to provide appropriate officer support.

The current thinking was that GP consortia would need to be sufficiently large to be able to commission effectively. The current assumption was therefore that consortia were likely to be bigger than previously envisaged or, alternatively, a number of smaller consortia might work together to obtain commissioning support.

It was noted that major reconfigurations were not popular and that the NHS had no specific plans to undertake any locally. However, Members expressed concern that strategic thinking and planning might be lost with the demise of bodies that had previously been responsible for this.

GP's and clinical leaders had identified the following seven clinical areas that they considered needed to be focussed on.:-

a. Long Term Conditions
b. Maternity
c. Paediatrics
d. Cancer
e. Cardiovascular disease
f. Unscheduled care
g. Mental Health

These areas had the largest expenditure, the largest patient group with growing demand and where services were varied. With regard to the inequalities in cancer care Members asked to see the evidence behind this.

The proposals were for a menu of current service initiatives to be developed, collectively called a QUIPP (Quality Innovation Productivity and Prevention) Plan. A plan to address the budget deficit was hoped to be produced by January 2011. It was noted that an ongoing challenge was to improve clinical quality whilst reducing spend. A suggestion was made that there should be a London wide strategic group looking at the NHS across London. A four year QUIPP was being developed (2011/12-2014/15) known as a Commissioning Strategy Plan or CSP for North Central London. The current long list of initiatives could be grouped into

either clinical priority work streams or cross cutting QUIPP themes which it was agreed would be areas for this body to explore progress made. It was hoped that, with efficiencies to be made within the clinical priority areas the deficit could be reduced over the next four years to around £173m.

NHS North Central London would be looking to Local Authorities for support on how to reshape services so that they become more locally accountable.

In response to an enquiry about problems with internal tariffs it was noted that tariffs for over 70% of acute care were nationally set and that they were difficult to challenge. Although there were proposals over the next four years for the tariffs to become a minus figure as part of the efficiency drive, this would not resolve local issues and the NCL would remain accountable for its overspend. It was hoped that a white paper on public health sector grants due out in December 2010 would explore what were core public health functions and whether there was commissioning through Local Authorities or GP's, for which currently the budget was split. The surpluses held by acute providers and the underuse of some hospital buildings, especially as services moved out of them were considered to be major issues. It was felt that the decision must driven by primary care needs.

With regard to GP practices being fit for purpose, it was noted that they would have to conform and be part of the commissioning consortium which every practice would have to join by 2014. PCTs had previously had a role in improving performance of GPs and they had revenue and capital funding to support improvement. Consortia could possibly develop their own incentives for practices to improve. In addition, local authorities could have a role in assisting with the re-validation process for GPs.

RESOLVED:

1. That members be circulated with evidence supporting the report.
2. That future meetings receive reports on the challenges and that officers develop a programme to enable the Committee to examine the areas of proposed savings in more depth.
3. That regular reports be presented to this body on progress being made with regard to GP commissioners.
4. That information be provided on the flows of patients using A & E services

7. NHS NORTH CENTRAL COMMISSIONING STRATEGY PLAN 2011/12 – 2014/15

Kate O' Regan from the NHS North Central London gave an update on the work taking place in the mental health work programme. The Committee noted that each Trust provider had a different set of organisational

priorities. The Barnet, Enfield and Haringey Mental Health Trust Transformation Programme set out to facilitate whole system change to improve local mental health services and to achieve cost efficiencies. Details of the nine work teams working on the transformation programme would be circulated to members and a progress report would be presented to the next meeting.

Camden and Islington NHS Foundation Trust were undertaking a savings programme and would shortly be carrying out a formal consultation into a proposal to close impatient beds and to reduce the number of inpatient sites. The identification of new care settings out of hospital settings, was moving forward. This would mean that service users received care nearer to their homes. Alcohol, Dementia and meeting the needs of people from Black and minority ethnic groups had been identified as priority areas for further care pathway development work across areas including general hospital and primary care settings.

It was noted that changes affecting all five boroughs should come to this body, consideration needed to be give to consultations involving less than all five but more than one borough It was agreed that officers would consider a way forward and report back.

Some concern was expressed over methods that may be used to consult with service users and it was suggested that these should be held in local settings such as schools. The NHS advised that they had a very well established network of advice on how to involve service users and there was regular contact with them, this included regular newsletters and meetings had been held. It was agreed that CAMHS social care interface was crucial and that CAMHS was a service which operated better at a local level. Some concern was expressed about the way that CAMHS would be commissioned, which it was felt could be helped with the development of some common standards. Also there was a need to raise GP's awareness of mental health issues and to clarify mechanisms for GP consortium to consult locally. Members welcomed the proposals and agreed that they would look closely at how the transition worked. Furthermore it was considered that more work around prevention was needed.

RESOLVED:

1. That details of the nine work teams engaged on the BEH MHT Transformation Programme be circulated to Members and a progress report be presented to the next meeting.
2. That officers be asked to consider how strategic issues affecting more than one borough but less than all five could best be progressed and report back..
3. That this Committee give further consideration to engagement with GP's around mental health issues and capacity building.
4. That information be provided in respect of the local consultation on the proposals

8. TRANSITION TO GP COMMISSIONING

Members were advised of the NCL proposals for a single transition organisation and priorities to be delivered in the transition period. In addition to shifting commissioning responsibilities to GP consortia the White Paper "Liberating the NHS" proposed a national commissioning board, a national primary care function and transfer of health improvement functions (public health) to local authorities. Additionally PCTs were required to reduce management costs by half and shift funding into front line services.

It had been agreed that the five PCT's would establish a single transition team from April 2011 to lead the transition process and to enable the saving of over half of the current management costs and maintain existing services. It was proposed that functions would be centralised wherever possible and a borough presence would be provided to deliver savings plans, to support the development of GP consortia and the further integration of public health and joint commissioning. PCT Boards would remain in place until 2013 supported by the local borough-based teams.

There remained much uncertainty as to what part of the PCT would transfer to the national commissioning board, or the primary care services, what form the GP consortia would take, and how quickly staff would transfer to local authorities or elsewhere. It was noted GP Consortia could apply for pathfinder status from December 2010, which would enable them to take on commissioning responsibilities from PCT's from April 2011.

It was noted that by 31 March 2011 there would be over a 50% reduction in staff employed by the PCT. Members expressed serious concerns of the timescales, the potential loss of staff expertise and whether GPs would be ready for the changes.

It was considered that local Health and Well being boards could be involved in working with borough based teams building relationships with local authorities, GPs, Links and other stakeholders in designing the new NHS.

RESOLVED

That the report and concerns expressed be noted.

9. BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY

Subsequent to the halting of the strategy in May 2010 an update was given on the Barnet, Enfield and Haringey Clinical Strategy and it's review against the four tests which had been laid down by the Secretary of State for Health. The review against the four tests was in four stages, the accumulation of which would be that a BEH Strategic Coordination group

on 30 November 2010 would receive an analysis from an independent organisation advising on whether the four tests had been met. Following this it was hoped that the Strategy would be submitted to NHS London.

Members expressed concerns over the implications of the strategy not being implemented for the North Middlesex Hospital. It was noted that, in the event of this happening, the hospital would be unlikely to be able to obtain foundation status and might not survive as an independent entity.

It was hoped that the Strategic Coordination Group would submit its report and supporting evidence to the NHS London by 1 December 2010 and that they would aim to conclude their findings in January 2011.

RESOLVED

That the report be noted.

10. NOTES OF LAST MEETING

The notes of the Informal meeting held on 2 August 2010 were noted. The Committee reiterated the importance of getting the correct population data in order to maximise any grants available.

11. NEW ITEMS OF URGENT BUSINESS

None

12. ANY OTHER BUSINESS

AGREED:

1. Health and Well being Boards be requested to receive updates on the GP Consortia. GP Consortia to be invited to attend future meetings of this body.

2. That this Committee meet every two months. Date of next meeting Friday 21 January 2011 10AM – 1PM in Haringey.

3. That the Director of Public Health be invited to a future meeting to discuss the public health consultation.

GIDEON BULL
Chair

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THE NHS IN NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL

REPORT TITLE: **A New Model for Arterial Vascular Surgery Services**

REPORT OF:

Nick Losseff
Consultant Neurologist and Clinical Director, NHS North central London
Senior Responsible Officer, QIPP, NHS North Central London.

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 21st January 2011**

SUMMARY OF REPORT:

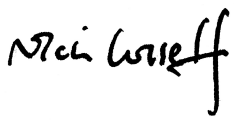
This report provides an update on work being undertaken in the NHS in North Central London in response to the recently-published Cardiovascular Strategy for London.

CONTACT OFFICER:
Sylvia Kennedy
Director of Clinical Strategy
NHS North Central London
Telephone 0203 317 2794
Email sylvia.kennedy@islingtonpct.nhs.uk

RECOMMENDATIONS:

The Committee is asked to note the content of this report and the appendices, and to raise any concerns or queries and to give their views on the work to improve local cardiovascular services, in line with the Cardiovascular Strategy for London.

SIGNED:



Dr Nick Losseff
Clinical Director, NHS North Central London
DATE: 14 January 2011

A New Model for Arterial Vascular Surgery Services

Strategy for London

The NHS has recently published a "Cardiovascular Strategy for London". This follows the completion of a public consultation on the clinical case for change, in which the strategy received a significant level of support with 83% of respondents in agreement with the proposals.

London NHS sectors, including ours in North Central London, are now in the process of examining how the strategy pertaining to Vascular Surgery can be implemented. The intention is that there should be five specialist vascular centres in London.

Vascular services in North Central London

Within North Central London there are currently three significant providers of arterial vascular surgery, based at Barnet Hospital, the Royal Free Hospital and University College Hospital. However, none of these centres is delivering the volume of work needed to establish a critical mass of patients or clinical expertise considered necessary to further improve patient outcomes. Indeed, given current activity levels, only one centre in North Central London is required to meet the needs of our population.

We have no doubt that moving forward to one specialist vascular centre, working in conjunction with a vascular network across North Central London, will present significant challenges and will require a high degree of co-operative working between service providers.

The absolute procedural numbers are small and the benefits to patients of establishing a single service are significant. These benefits should mirror what has already been achieved in other specialities, for example stroke and coronary heart disease.

Therefore, it is our intention to commission a service for North Central London residents as closely aligned to the consulted cardiovascular strategy as possible, and this service development is a high priority within our QIPP (Quality Innovation Productivity and Prevention) plan for the coming year.

We have proposed a co-operative solution be developed by the three service providers in the first instance (see Appendix One). Such an approach would remove the need for an independent designation process to be run.

At the same time, we are developing a designation process through which we could fairly establish which provider could lead the vascular service of the future, should a co-operative proposal not be forthcoming.

We had asked for this co-operative solution to be presented by mid January. At the time of writing this paper, a solution had not been reached. However, Dr Nick Losseff will update Committee Members at the meeting on 21 January.

We are aware that, at a clinical level, a group of North Central London vascular surgeons already meets to discuss provision, and we have offered to host further talks with the view of establishing a co-operative solution if this is required.

Implementation of the change in our sector will be supported by the North Central Cardiac and Stroke Network.

Engagement

We recognise that it is important to keep our partners fully briefed on service developments like this. All Primary Care Trusts in North Central London have now sent a letter and summary document (attached as Appendices Two and Three) detailing the essential components of the proposed network and vascular service in London to the relevant councillors within their borough. We will continue to engage relevant stakeholders as the new model is developed.

North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

VIA E-MAIL:
To All Acute Trust Chief Executives
Acute Trust Medical Directors
Vascular Providers

Sector Chief Executive's Office
6th Floor, Stephenson House
75 Hampstead Road
London
NW1 2PL

Tel: 020 3317 2865
Fax: 020 7685 6210

rachel.tyndall@islingtonpct.nhs.uk

7th December 2010

Dear Colleagues,

Vascular Surgery

We write further to the published Cardiovascular Strategy for London which has now finished consultation and has received a highly significant level of support, with 83% of respondents in agreement with the proposals.

London Sectors are now in the process of examining how the strategy pertaining to Vascular Surgery can be implemented, with the intention that there should be 5 specialist vascular centres in London. Within North Central London there are three significant providers of arterial vascular surgery based at Barnet, The Royal Free and UCLH. No one centre is delivering the volumes of work needed to establish the critical mass of patients and expertise considered necessary to further improve patient outcome and our working lives, indeed given the current activity only one centre in North Central London can be justified.

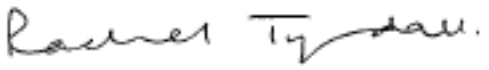
We have no doubt that moving forward to one specialist centre, working in conjunction with a vascular network across NCL presents significant challenges and will require a high degree of co-operative working between providers. Nevertheless the absolute procedural numbers are small and the benefits to patients of establishing such a service are clear. These benefits should mirror what has already been achieved in other specialities. Therefore it is our intention to commission a service, as closely aligned to the consulted cardiovascular strategy as possible, and this service development is a high priority within our QIPP plan for 2011/12.

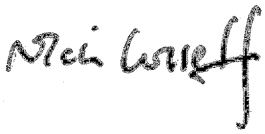
Sectors are moving in different ways towards implementation. We propose and hope to seek a co-operative and acceptable solution from providers in the first instance. This would remove the need for an independent designation process to be run. We propose that such a solution (in principle) would need to be agreed by 14th January 2011, but we will be running in parallel the development of process which could fairly establish who best could provide the service of the future should a co-operative and acceptable solution not be forthcoming.

We are aware that at a clinical level a NC group of vascular surgeons already meets to discuss provision, and we would be happy to host further talks with the view of establishing a co-operative solution if this was necessary.

We enclose a summary document detailing the essential components of the proposed network and vascular service. Implementation of the change will be supported by the NC Cardiac and Stroke Network, as in the recent changes in stroke provision.

Yours sincerely,





Rachel Tyndall
Sector Chief Executive
NHS North Central London

Dr Nick Losseff
Secondary Care Clinical Director
NHS North Central London

North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

EXAMPLE LETTER TO COUNCILLORS

Chief Executive
NHS [INSERT PCT]
[INSERT ADDRESS]
Tel: [INSERT]
Fax: [INSERT]
[INSERT EMAIL]

[DATE]

RE: Arterial vascular surgery provision in North Central London

Dear [insert councillor],

As you may already know, the NHS has recently published a "Cardiovascular Strategy for London[1]". This follows the completion of a public consultation on the clinical case for change, in which the strategy received a significant level of support with 83% of respondents in agreement with the proposals.

London NHS sectors, including ours in North Central London, are now in the process of examining how the strategy pertaining to Vascular Surgery can be implemented. The intention is that there should be five specialist vascular centres in London.

Within North Central London there are currently three significant providers of arterial vascular surgery, based at Barnet Hospital, the Royal Free Hospital and University College Hospital. However, none of these centres is delivering the volume of work needed to establish a critical mass of patients or clinical expertise considered necessary to further improve patient outcomes. Indeed, given current activity levels, only one centre in North Central London is required to meet the needs of our population.

We have no doubt that moving forward to one specialist vascular centre, working in conjunction with a vascular network across North Central London, will present significant challenges and will require a high degree of co-operative working between service providers.

The absolute procedural numbers are small and the benefits to patients of establishing a single service are significant. These benefits should mirror what has already been achieved in other specialities, for example stroke and coronary heart disease.

Therefore, it is our intention to commission a service for North Central London residents as closely aligned to the consulted cardiovascular strategy as possible, and this service development is a high priority within our QIPP[2] plan for the coming year.

We have proposed a co-operative solution be developed by the three service providers in the first instance. Such an approach would remove the need for an independent designation process to be run.

[1] http://www.csl.nhs.uk/Publications/Pages/ProjectPublications.aspx?tags=8&tagDisplayName=Cardiovascular
[2] QIPP – Quality, Innovation Performance and Prevention

We propose that a co-operative solution would need to be agreed by the providers by 14 January 2011. At the same time, we will be developing a designation process through which we could fairly establish which provider could lead the vascular service of the future, should a co-operative proposal not be forthcoming.

We are aware that, at a clinical level, a group of North Central London vascular surgeons already meets to discuss provision, and we have offered to host further talks with the view of establishing a co-operative solution if this is required.

At the same time we recognise that it is important to keep you, our partners in local authorities, fully briefed on service developments like this. We enclose a summary document[3] detailing the essential components of the proposed network and vascular service in London. Implementation of the change in our sector will be supported by the North Central Cardiac and Stroke Network.

If you would like to know more please do not hesitate in contacting me or Sylvia Kennedy, Director of Clinical Strategy at NHS North Central London on 0203 317 2794 or sylvia.kennedy@islingtonpct.nhs.uk

Yours sincerely,
[SIGNATURE]

[NAME]
Chief Executive

Enc: NHS Commissioning Support for London, London cardiovascular services: Proposed model of care

Copies emailed to:
[INSERT RELEVANT COUNCILLORS, SCRUTINY MANGER, PCT AND COUNCIL DIRECTOR/S]

[3] http://www.csl.nhs.uk/Publications/Documents/LondoncardiovascularservicessummaryofProposedmodelofcare.pdf

Commissioning Support for London

London cardiovascular services:
Proposed model of care

Summary

Contents

Foreword

Improving outcomes for patients is at the core of these proposals to improve cardiovascular treatment and care in London. Many lives will be saved and strategies will be put in place to meet the growing demand of an ageing population.

The model of care has been developed following a comprehensive assessment of how services are currently provided in the capital, a robust review of clinical evidence and a review of national and international best practice. Whilst this project focuses on care in hospitals, other important patient issues are also addressed in the patient perspective paper.

Key to the proposals were the recommendations of the patient panel. We have direct experience of being treated in London hospitals for varying types of cardiovascular disease. We were able to shape the project recommendations and in partnership with the clinical groups, ensure that the project recommendations would improve the experience for patients and families.

In addition to chairing the patient group, we also attended all of the clinical expert panel meetings. There were three multi-professional clinical expert panels each focusing on a specific area of work – vascular services, cardiac surgery and cardiology. This truly meant that recommendations came out of partnership working between clinicians and patients.

We want this document to be used by London's commissioners to commission the world-class cardiovascular services all Londoners deserve. In practice, this means achieving better outcomes for patients including:

- Saving more patients' lives
- Increasing the speed and equity of services
- Improving patient access

- Reducing the length of time spent in hospital
- Meeting unmet needs
- Improving the use of new technology and research
- Making the best use of NHS resources and saving public money.

We believe that this work addresses these issues and sets out a blueprint for providing the highest quality services for all Londoners.

Martin Saunders and Jeremy Gold
Co-chairs of the cardiovascular project patient panel

Reviewing London's cardiovascular services

Patients undergoing cardiovascular surgery in London deserve the best service in the world. While pockets of excellence exist, evidence shows that there is much that needs to be done to improve outcomes and patient experience across the capital.

Commissioning Support for London was tasked with reviewing London's acute and specialist cardiovascular services in July 2009. The project has developed two main documents: a case for change and a proposed model of care. The case for change is a thorough review of the current provision of acute and specialist cardiovascular services in London and a review of the clinical evidence. The model of care proposes how London should change in light of this evidence to improve care.
The full documents are both available online at www.csl.nhs.uk.

How the project worked

The project was clinically led by Prof Matt Thompson, Vascular Surgeon, St Georges Healthcare Trust, and was supported by Caroline Taylor, Chief Executive, NHS Croydon, as the Senior Responsible Officer. The project was divided into three clinical areas and had a clinical lead nominated to develop that area of work:

- Vascular surgery, led by Prof Nick Cheshire, Vascular Surgeon, Imperial College Healthcare NHS Trust, London.
- Cardiac surgery, led by Mr Steve Livesey, Cardiac Surgeon, Southampton University Hospital.
- Cardiology, led by Dr Huon Gray, Cardiologist, Southampton University Hospital.

Led by the respective clinical lead, each area of work had an associated clinical expert panel. The panel was made up largely of hospital doctors and other hospital-based healthcare professionals from trusts across the capital.

The project was also advised by a patient panel. The panel was made up of members of the public who had first-hand experience of being treated for cardiovascular disease. Both co-chairs of the patient panel also sat on the clinical expert panels to ensure that the patient voice was consistently incorporated into the work as it was developing.

Work supporting the proposed model of care

During the project, it became apparent that some services would need to move around between different hospitals to align with the model of care. To help commissioners with this process, the clinical expert panels produced a “co-dependencies” framework that depicts the relationships and dependencies between hospital services. This paper is summarised in section 4.

The patient panel were also asked to produce a specific document – The Patient Perspective – which is summarised in section 5. This outlines the issues that are most important to patients and that will need to be addressed to achieve a truly patient-focused service.

The project has also assessed its recommendations from a financial perspective. The purpose of this is to reassure commissioners that the project recommendations are affordable and in some cases, could save the NHS money, which could then be reinvested into other frontline services.

Engagement

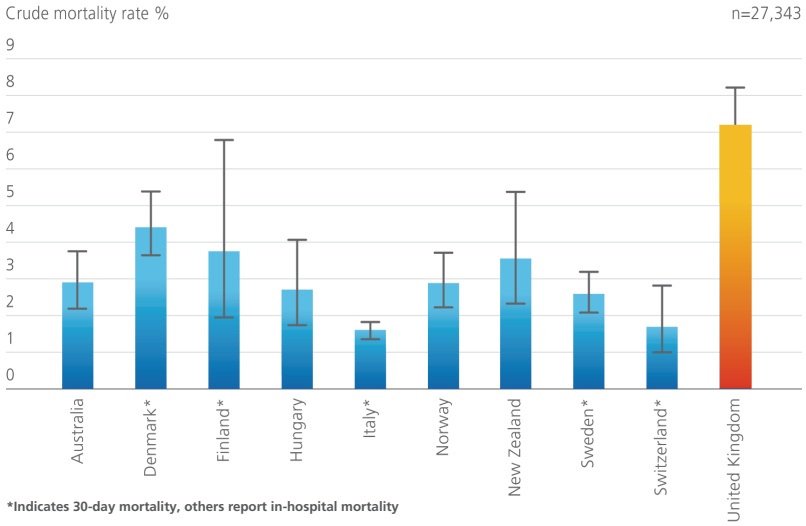
An engagement event was held in November 2009 to seek feedback on the draft case for change and emerging model of care. The event was attended by over 80 people, including patients, clinicians and third sector organisations. The feedback received from the event was documented and fed into the development of the project documents.

This document is a summary of the review, encompassing the case for change, proposed model of care and supporting documents. It outlines an ambitious, evidence-based, patient-focused way to improve London's cardiovascular services.

Vascular surgery

The UK has the worst mortality rates following arterial vascular surgery in the developed world. While some nations are able to achieve mortality rates as low as around 2%, the UK is almost four times that figure at nearly 8%. In London each year, around 3,000 people in London undergo this type of surgery.

Figure 1: Crude mortality rates displayed by country for elective abdominal aortic aneurysm repair



Clinical evidence in vascular surgery highlights the following four factors that influence outcomes following arterial vascular surgery.

1. Vascular surgery should be undertaken by a specialist vascular surgeon

Experienced vascular specialists have significantly improved mortality outcomes of around 2-4% when compared to a general surgeon doing vascular surgery. In some London hospitals, vascular surgery is still undertaken by a general surgeon.

2. Modern surgical technologies

Some vascular procedures can be done using a modern, minimally invasive surgical method called endovascular surgery. Evidence shows that this type of surgery reduces length of hospital stay, reduces the risk of acquiring a hospital infection and most significantly, reduces surgical mortality by around 3% compared to traditional surgical methods.

In London, there is a significant variance in the uptake of minimally invasive vascular surgery. This means that the hospital where the patient has their surgery is a bigger determining factor in deciding the type of surgery they will have rather than their clinical need.

3. Individual surgeons should maintain high volumes of surgery

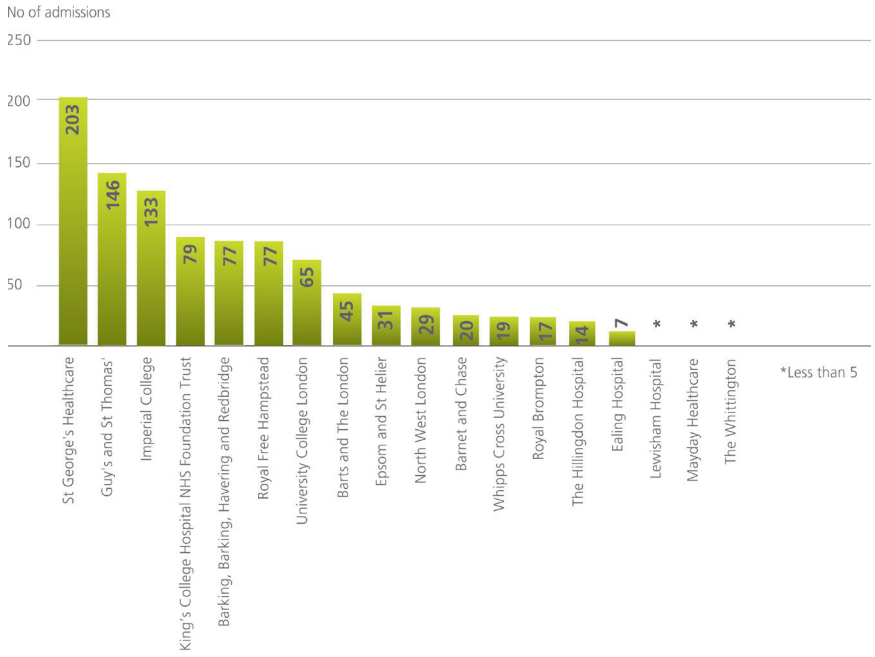
Surgeons that maintain high volumes of vascular surgery achieve mortality rates 2-4% lower than surgeons that perform low volumes of vascular surgery each year.

4. Institutions should perform high volumes of vascular surgery

Hospitals performing high volumes of vascular surgery achieve significantly lower mortality than hospitals performing low volumes. Recently published data demonstrated mortality at one low volume London hospital to be 8.5%, compared to the high volume London hospitals which had mortality rates in the region of 2%. Evidence also shows that this is an increasing trend – as the volume of surgery continues to increase, the mortality rates continue to decrease.

NHS activity data from 2007/08 for London hospitals demonstrated that about 75% of surgery took place in six hospitals and the other 25% is spread across the remaining 13 hospitals. This wide distribution of surgery is not conducive to achieving the best outcomes for patients.

Figure 2: Trusts in London performing abdominal aortic aneurysm surgery and associated volumes of cases for 2008/9



A new way of working

To meet the challenges set out by the clinical evidence, hospitals providing vascular surgery should work together in a network of local and central sites to ensure that all patients receive consistent, high quality care.

Local sites will continue to provide a quality local vascular service, including outpatients, diagnostics and day surgery for venous procedures.

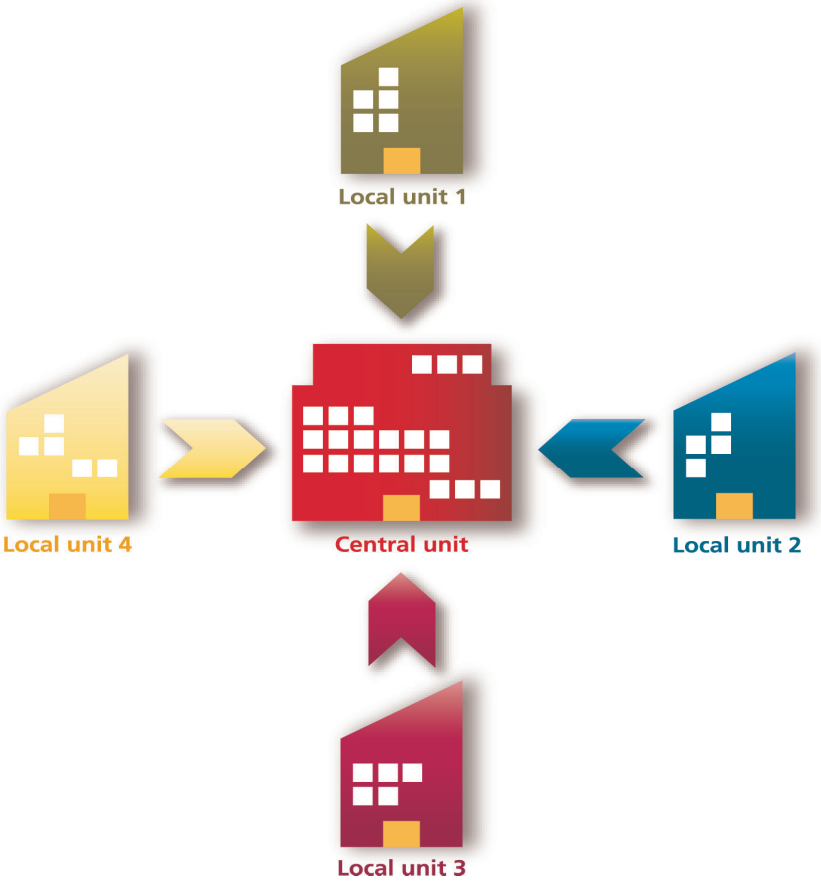
Emergency and elective arterial vascular surgery should only be performed at one central site in each network to ensure that:

- Patients have more access to specialist vascular surgeons
- The rates of endovascular surgery increase

- Individual surgeon volumes can be monitored
- Institutions providing arterial surgery will achieve high volumes
- Mortality outcomes will improve.

Based on data in Figure 2, clinical evidence, the need for a stable surgical rota and the need to provide an equitable service, the clinical expert panel recommended that there should be five central sites in London, each working with their associated network of local hospitals.

Figure 3: Proposed structure of vascular network



Questions

1. Do you agree that the clinical evidence provides a compelling case for change for vascular surgery?
2. Do you agree that arterial vascular surgery should be centralised onto five sites across London?
3. Which components of vascular surgery do you think should be delivered locally?

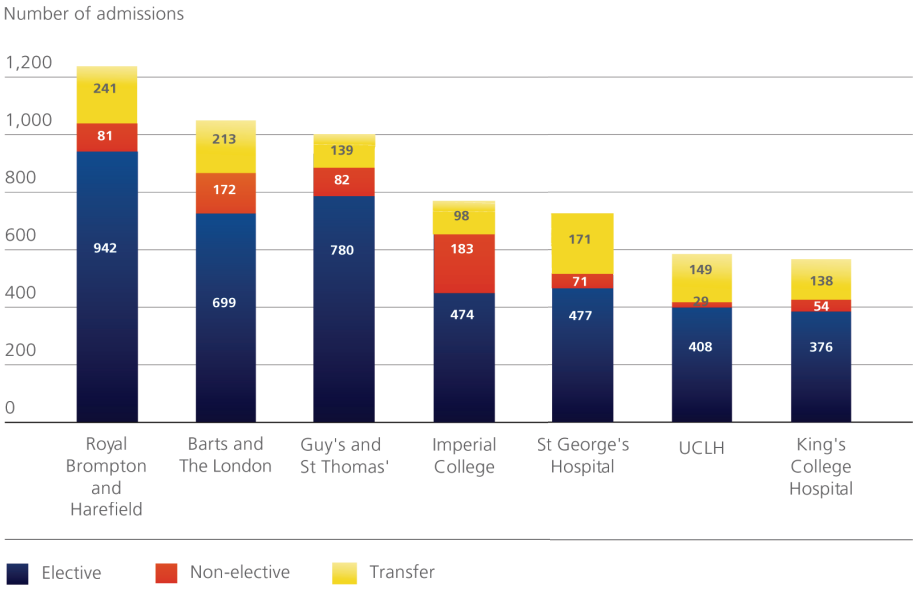
Cardiac surgery

Non-elective cardiac surgery pathways in some areas of London have a total pathway length of over 50 days. The UK average is 20-25 days and the US average is just 14 days. Evidence shows that patients have an increased risk of mortality the longer they wait. For patients suffering an aortic dissection, mortality rates in the capital are over 20%.

Over 24,000 people had cardiac surgery in London between 2004 and 2007. Although mortality rates are low, the Society for Cardiothoracic Surgery's 2008 report stated: "counting deaths after surgery is no longer a useful measure of quality-of-care". The clinical panel noted three areas where cardiac surgery services in London should improve.

1. Improving non-elective cardiac surgery

Figure 4: Admission method for patients undergoing coronary artery bypass grafting surgery in London in 2008/9

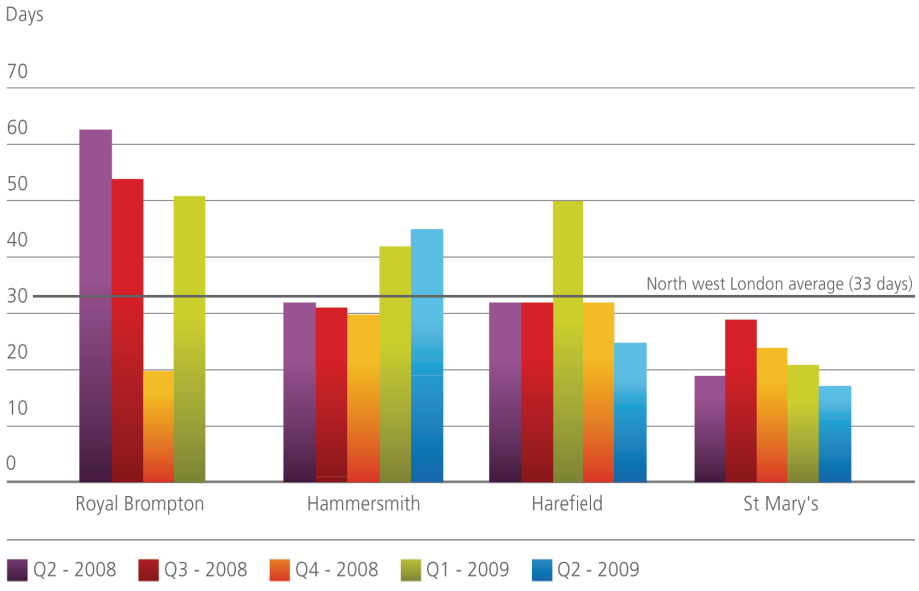


The proportion of cardiac surgery conducted on an urgent or non-elective basis is increasing. As seen in Figure 4, about a third of all cardiac surgery is performed on this basis in London.

Non-elective cardiac surgery is not subject to national waiting times monitoring. This means that patients requiring urgent surgery often wait longer than they should. Clinical evidence shows that the risk of death increases month on month the longer a patient waits for surgery.

Most non-elective patients are transferred from their local hospital to a specialist cardiac surgical hospital for surgery. This process of transferring and receiving the patient in a specialist hospital is the major cause of delay. In some areas of London, this process is taking in excess of 50 days. The UK average is 20-25 days and in the US, the average total pathway length is 14 days.

Figure 5: Total pathway length, displayed by quarter across cardiac surgery centres in North West London



To address these issues, the clinical expert panel recommended the following for patients requiring non-elective cardiac surgery:

- Mandatory use of an electronic referral system
- Agreed evidence-based clinical protocols to establish the need for surgery
- Patients should be risk-stratified to determine priority for surgery
- At receiving units, referrals should be managed by case managers and reviewed by the surgical team on the day of referral
- The panel also proposed that waiting times at receiving units are monitored via an electronic referral system.

Waits should not exceed the following standards for 90% of patients:

- The total pathway length should not exceed 21 days
- The time between admission to the local hospital and referral to a surgical unit should not exceed five days
- Time between referral and transfer should not exceed five days
- Length of stay at the surgical centre should be 11 days or less.

2. Mitral valve surgery

The mitral valve controls the flow of blood into the heart. When this valve becomes diseased, one treatment option is surgery. There are two ways in which surgery can be undertaken on the mitral valve, either it can be repaired or it can be replaced with a prosthetic valve.

The clinical evidence in this area shows that for patients having surgery for degenerative mitral valve disease, better outcomes are achieved when the valve is repaired, rather than replaced.

There is also an increasing trend internationally to sub-specialise mitral valve surgery. This would mean that mitral valve surgery

should only be conducted by individuals who perform high volumes of this procedure, rather than by individuals who perform low volumes of a variety of different cardiac surgery procedures. By sub-specialising mitral valve surgery, only teams of experienced, specialist surgeons would undertake the procedure, improving outcomes for patients.

3. Cardiothoracic aortic disease

Aortic dissection is an emergency life threatening condition which occurs in the upper regions of the aorta in the chest cavity. Data indicates that the mortality for the 100 or so patients suffering from this condition per year in London is 20%.

At present, the emergency care for these patients is disorganised. Aortic dissection procedures are invariably undertaken by an on-call surgeon. This surgeon may, or may not, be a cardiac or vascular surgeon with experience in aortic disease, meaning that this may be the only aortic dissection case they undertake in a year. Patients are receiving their surgery based on where beds are available rather than where the expertise is.

To reduce the surgical mortality rate:

- Patients should have prompt assessment and treatment by a Specialist experienced surgeon
- Treatment should take place at a specialist site – patients presenting at a non-specialist site should be immediately transferred
- Specialist sites must have the support of other co-dependent specialties available on-site (e.g. vascular surgery).

Questions

1. Do you agree that services to patients requiring non-elective cardiac surgery should be improved?
2. Do you agree that the use of an electronic referral system, coupled with case managers in the receiving centres, is the

best method to reduce delays for non-elective surgery?

3. Do you agree that mitral valve surgery should only be conducted by specialist teams?
4. Do you agree that patients requiring surgery for aortic dissection should only be treated at specialist centres by specialist surgeons?

Cardiology

Death from heart disease remains the biggest killer in the UK and London. After one year, patients with serious coronary artery disease have the same likelihood of death as patients who have suffered a full heart attack. Treatment practices for these patients needs to change to reduce mortality.

The work of the clinical expert panel focused on two areas – services for patients with coronary artery disease and those with heart rhythm defects.

1. Services for patients with coronary artery disease

Coronary artery disease is the progressive narrowing or blocking of the arteries that provide the heart's blood supply. When these arteries become completely blocked, a so-called "STEMI" heart attack occurs. In London, ambulance paramedics detect this on an ECG machine, and then transfer the patient immediately to a hospital where they can receive emergency, evidence-based treatment, 24 hours a day, seven days a week.

Some patients experience severe chest pain when the coronary arteries become only partially blocked. Clinical evidence shows that after 12 months, some of these patients have the same mortality rate as patients who have had a full STEMI heart attack. For the purposes of this work, these patients are referred to as NSTEACS patients.

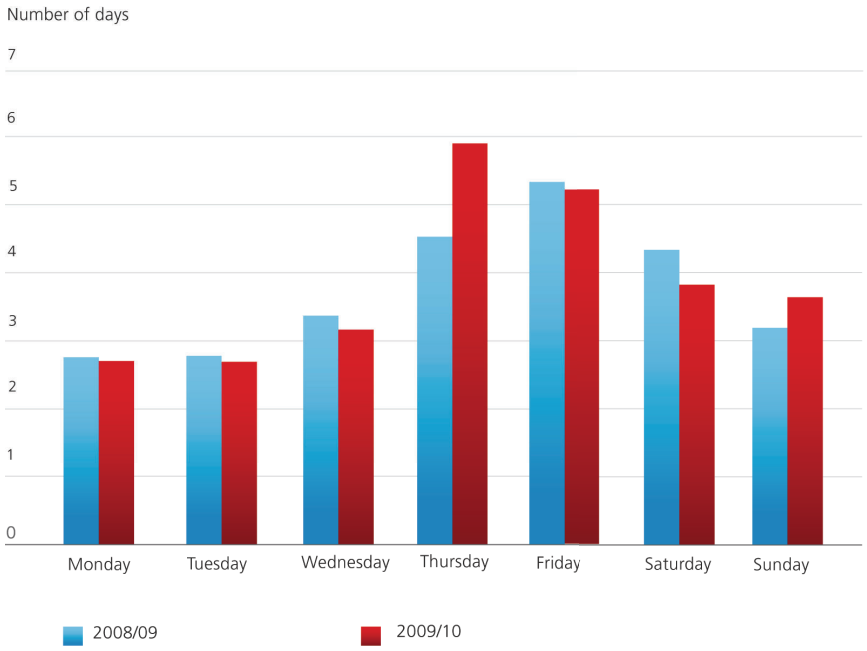
Recent NICE guidance and clinical evidence states that following risk stratification, "high risk" NSTEACS patients that have early access (24 to 72 hours) to diagnostic angiography have improved long-term mortality outcomes.

It is not possible to see an NSTEACS event clearly on an ECG machine. This means that patients in London are routinely taken to the nearest hospital. If it is subsequently decided that

the patient should have angiography, there are more delays – particularly associated with what day of the week a patient is admitted.

Patients admitted on a Monday, Tuesday or Wednesday are usually treated within two days. Those admitted on a Thursday or Friday have to wait over the weekend for their angiogram due to no weekend working. This is depicted in Figure 6.

Figure 6: Number of days waiting for an inpatient angiogram displayed by days of the week at one London hospital

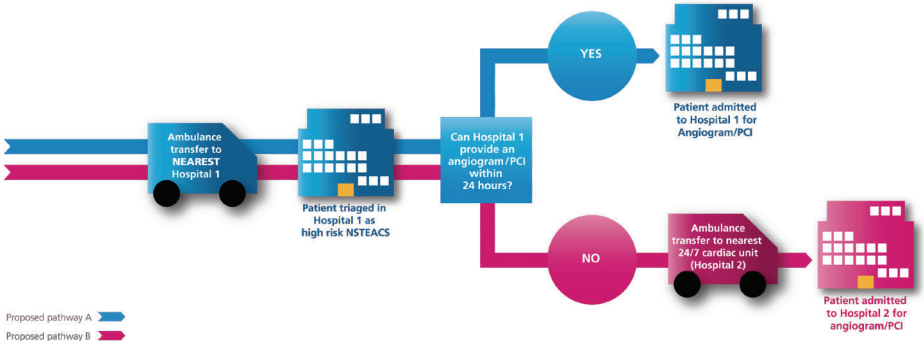


The proposed model of care recommends improvements to streamline the current patient pathway. The new pathway will:

- Diagnose and risk stratify patients early
- Manage patients according to their risk level through the use of an agreed evidence-based risk stratification tool
- Ensure that “high risk” patients are offered angiography within 24 hours of admission.

If the patient is triaged in a hospital that cannot provide angiography within 24 hours, then the patient should be transferred to a unit that can. Units wishing to provide this service should ensure that they are able to offer angiography on a seven day basis and provide commissioners with evidence of weekend working as required.

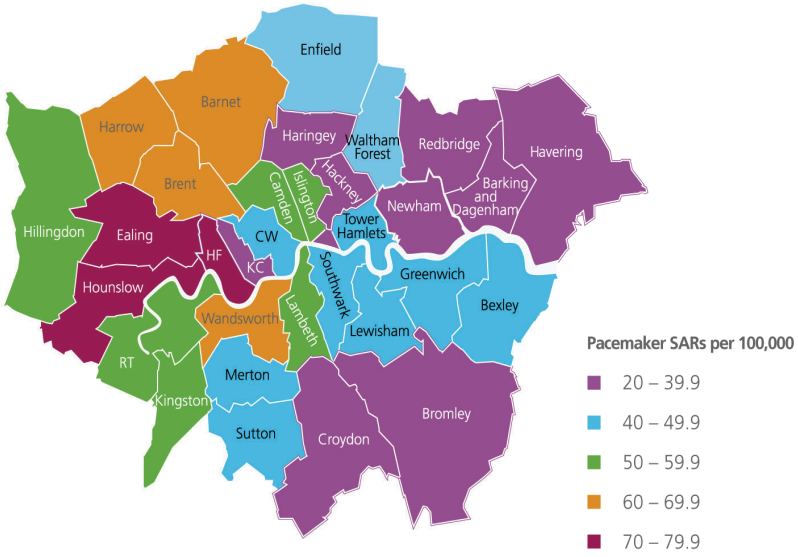
Figure 7: Proposed new pathway for high risk NSTEACS patients



2. Services for patients with heart rhythm defects

Evidence in this area shows that patients with uncorrected heart rhythm defects have a higher risk of heart failure and death. In the UK, we implant fewer corrective devices (such as pacemakers) per million population when compared to other western European nations. In addition, London data shows that the rates of device implantation vary hugely from area to area. This is depicted in Figure 8.

Figure 8: Per million pacemaker implantation rates across London 2008/9



In order to achieve the best outcomes, the NHS in London needs to ensure more patients with heart rhythm defects are identified for these corrective procedures. It is clear that among the factors responsible for the low rates of intervention in the UK is poor access to the relevant expertise.

The clinical expert panel developed several recommendations around how a new model of care could address this:

- Hospitals should work in networks to deliver these services, working closely to provide a coordinated service, with more cross-unit working of staff.
- Complex electrophysiological procedures should be delivered at central units within networks.
- Clinical expertise should be available in every hospital in the network to ensure patients receive the highest levels of care.
- Activity should be audited – performance and outcomes of services should be a mandatory for all units.

Central units should also be encouraged to offer specialist expertise to their referring hospitals. They should:

- Provide clinical support 24 hours a day, seven days a week so that urgent and emergency arrhythmia cases are managed promptly nd appropriately by a specialist
- Offer to undertake clinics in referring local units.

Questions

1. Do you believe that services should change for “high risk” NSTEACS patients?
2. Do you believe the model of care proposed for high risk NSTEACS patients is the right one?
3. Do you think that hospitals should come together as networks to treat patients with heart rhythm defects?

Cardiovascular co-dependencies framework

To support the implementation of the recommendations in the proposed model of care, a framework of co-dependencies between different cardiovascular services was developed by the clinical expert panels.

The framework is intended to provide commissioners with a set of recommendations to inform the provision of future services. It can also be used by commissioners and trusts as a benchmarking tool against current service provision.

The relationship between each cardiovascular service and other services was given a colour rating. These ratings were then mapped into a colour-coded grid.

The completed framework suggests a high level of dependency between acute and complex cardiovascular procedures, including cardiac surgery and complex vascular surgery. Further detail on the service relationships is available in the co-dependencies paper.

The patient perspective

As part of the work to develop a proposed cardiovascular model of care, the project patient panel produced a paper on the things that matter most to patients having treatment for cardiovascular disease. This paper is entitled “The Patient Perspective”.

The Patient Perspective sets out a series of recommendations to providers of cardiovascular services that the patient panel felt were instrumental to improve the patient experience.

As far as practicable, there should be continuity of care with the same medical team for a patient’s stay in any one hospital. Each patient should have a named nurse on each shift to whom they can address queries. Nursing staff are a critical part of care, especially on the ward. The rotation and use of agency nursing should be kept to an absolute minimum.

Consultants should clearly demonstrate their interest in all aspects of their patient’s situation such as bed comfort, feeding, cleanliness and hygiene and quickly take up any shortcomings with those responsible.

When a patient is first admitted to hospital, a consultant inpatient appointment should be offered at a time suitable for carers and relatives to attend to support the patient and to ensure that everyone fully understands the situation.

As the patient’s stay continues, they would welcome the presence of a carer or relative to help them remember and understand what they are told by their consultant, and to ask questions on their behalf. We recommend that hospitals facilitate this by publishing details of consultants’ ward rounds so carers or relatives can visit while they are in progress.

Without having to be asked, staff should offer explanations

of any medical terms and explain the purpose of all medications and treatments. Verbal information about medical conditions, procedures and future lifestyle advice should be supplemented by easy availability of written information.

Where patients' condition permits, staff should encourage them to talk to each over about their condition and treatment. Sharing information can be mutually supportive.

The prospect of any invasive treatment can be frightening, and the facility to discuss fears with a former cardiovascular patient is valuable, and should be available at all hospitals seven days a week. Although there may be some provision of counselling and psychological assessment in hospital prior to a procedure, this is an issue of simple reassurance from someone who has had personal experience of a similar condition. The aim would be to have a list of former patients willing to visit patients on request or speak with them on the phone.

When leaving hospital patients should be encouraged to keep a patient passport or similar wallet with them at all times, containing up-to-date medical information including discharge letters, latest medication, details of GP and consultants, ECG and echo results, ICD settings, any later hospital admissions or appointments, and any other papers the patient would like to have readily available in an emergency. This material would be useful for paramedics or other professionals in the event of future emergencies. In the longer term, the wallet should include a copy of a properly structured patient care plan.

Patients should be discharged to their GP and upon discharge, all patients should have a clear care plan which includes the name of a hospital contact. Any ongoing care that a patient needs should be decided on the basis of medical need and not the ability to pay.

Financial analysis of the proposed models of care

As part of the development of the model of care for cardiovascular services in London, the cost implications of the model for each area of work – vascular services, cardiac surgery and cardiology – have been evaluated. The evaluation involved a detailed analysis based on the recommendations proposed in each model.

For the purposes of this section, the financial implications for commissioners and providers are assessed separately. Where a commissioner will continue to pay the standard HRG tariff cost, resulting in a saving for providers through changes in the ways of working, this is stated as a saving only to providers. Where there will be a change to the number or type of HRG commissioners are paying, then this is stated as a saving to commissioners.

Vascular surgery

For vascular surgery, the analysis showed that the model of care was likely to cost London commissioners an additional £464,000 per year. This was largely due to the higher use of endovascular surgery, which due to the equipment used, is more expensive to perform when compared to open surgery.

Providers are likely to make an overall saving in the region of £700,000. This was largely down to reduced length of stay in the hospital, especially on the intensive care ward.

Cardiac surgery

Analysis of the cardiac surgery model of care indicated a cost saving for both commissioners and providers. For commissioners, the saving was likely to represent around £620,000 per year. This was mainly made up of savings from reductions in bed days and savings related to the increased

uptake of mitral valve repair, rather than replacement.

The savings for providers were likely to be very significant. Made up of length of stay reductions, providers for cardiac surgery will save in the region of £5.1m a year.

Cardiology

Changes in the finances related to the cardiology model of care are more difficult to model. This is because it is more difficult to be precise about the exact number of NSTEACS and electrophysiology patients that will be affected by the proposed model of care.

However, the most significant savings are likely to be for commissioners. As high risk NSTEACS patients will be transferred immediately to a centre that can provide an angiogram within 24 hours, commissioners no longer need to pay for two hospital admissions. This will save commissioners between £1.0m and £4.0m across London per year.

The electrophysiology aspect of the model of care will impact on commissioners. Again, as the exact increase in the uptake of devices is not known, the financial analysis provided a range of costs to commissioners of between £2.0m and £4.1m.

Conclusion of financial analysis

Although different parts of the project have different costs associated with them, it is important to note that these recommendations should be taken in the round, to improve the entire service to patients. The project patient panel felt strongly that recommendations should not be chosen for implementation based only on a cost analysis.

Conclusion

The cardiovascular case for change highlighted considerable scope for improving cardiovascular services in London. It found the NHS in London could improve outcomes, quality and equity of access, as well as enhancing patients' experience.

The proposed model of care makes a number of recommendations to address the issues raised in the case for change and sets out a blueprint for the highest quality services possible to be available to Londoners.

Key proposals include centralising services where this would improve outcomes; reduce hospital stays; improve patient pathways; and have a greater sub-specialisation of surgeons delivering complex procedures and improvements in the way providers work together to deliver services.

The recommendations outlined in the model of care are designed to help and support commissioners in London to develop a world-class service for cardiovascular patients.

Full implementation should see a major improvement in the treatment, care and outcome of London's cardiovascular patients over the coming years, as well as reducing costs for the NHS. This is particularly important as the requirement for services grows, while NHS funding becomes tighter.

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- Iain Thomas – South West London Cardiac Network
- Sirkka Thomas – Patient Carer, South West London
- Lyn Wheeler – South East London Cardiac Network
- Barry Silverman – Patient and Public Advisory Group
- Michael English – Patient and Public Advisory Group
- Dilmohan Bhasin – Patient and Public Advisory Group
- Susan Jackson – Patient and Public Advisory Group

Vascular surgery

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- Mr Peter Taylor, Consultant Vascular & Endovascular Surgeon, Guy's & St Thomas' NHS Foundation Trust
- Dr David Evans, Consultant Interventional Radiologist, King's College Hospital NHS Foundation Trust
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- Dr Martyn Thomas, Clinical Director for Cardiovascular and Consultant Cardiologist, Guy's & St Thomas' NHS Foundation Trust
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- Dr Nick Bunce, Consultant Cardiologist and Medical Director for South West London Cardiac Network, St George's Healthcare NHS Trust
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- Jeremy Gold (Co-Chair) – North Central London Cardiac Network
- Martin Saunders (Co-Chair) – Patient and Public Advisory Group

Glossary

Abdominal aortic aneurysm - an aneurysm occurs when a weakened section of the artery is stretched and balloons out, increasing to many times its normal size. The wall of the artery becomes thin and as the aneurysm grows and the artery becomes more likely to burst

Angiography / angiogram - is an interventional diagnostic procedure used to detect the level of coronary artery disease around the heart

Aortic dissection - this is a tear in the wall of the aorta that causes blood to flow between the layers of the wall of the aorta and forcing them apart

Arterial vascular surgery - is the term used to describe a group of vascular surgical procedures on the arteries. This includes surgery for an abdominal aortic aneurysm, carotid endarterectomy and lower limb artery bypass procedures

Coronary artery bypass graft - bypassing narrowed segments of the arteries, which supply the heart muscle with blood, using veins and arteries taken from behind the breast bone, the leg or the arm

Coronary artery disease - the progressive narrowing of the arteries around the heart. This starves the heart of the oxygenated blood that it needs to function properly

ECG - stands for “electro cardiogram” and is a machine used to trace the electrical activity in the heart

Elective - this is the term for routine scheduled surgery

Endovascular surgery - uses a percutaneous technique to access

the artery, which is less invasive than open repair. During the procedure, an incision is made in the groin and a stent graft (an artificial, metal reinforced, fabric tube) is fed to the site of the aneurysm and deployed

Heart rhythm defects - the medical term for this is an "arrhythmia". This term is used to describe a heart that is not beating in the normal sequence

HRG - stands for "Healthcare Resource Group" and is a code or group of codes given to healthcare procedures which have a price associated with them. Hospitals are paid this price for each procedure they undertake

Mitral valve - the mitral valve is the main inlet valve of the heart. The most common condition affecting this valve is called "regurgitation" due to degenerative mitral valve disease

Non-elective - this is the term for surgery that was not scheduled to take place – it usually happens on an urgent or emergency basis

NSTEACS - stands for "non ST-elevation acute coronary syndrome" and is a term used to encompass patients who have either unstable angina (chest pain) or are having a less severe heart attack that cannot be seen on an ECG machine

Pacemaker - is a small device, implanted under the collar bone which is connected to the heart to help it to beat in the correct rhythm

STEMI - stands for "ST-elevation myocardial infarct" and is a type of severe heart attack

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Proposed service specification for a centralised arterial vascular surgery unit

1. Procedures

A centralised arterial vascular surgical unit should be commissioned to undertake the following procedures on both an emergency and elective basis:

- Abdominal aortic aneurysm surgery (both open and endovascular surgery should be commissioned)
- Carotid endarterectomy surgery
- Lower extremity arterial bypass surgery

In addition, the following other vascular procedures should also be commissioned from the centralised units:

- Varicose vein surgery
- Any other day-case venous vascular surgery
- Surgery on the lymphatic system
- Limb angioplasty
- Amputations

2. Emergency service

The centralised unit should offer an emergency arterial vascular service on a seven day a week, 24 hour basis. Patients having emergency surgery on their arteries should receive that surgery in the same site as the elective service.

Patients that present at a local unit who require emergency arterial vascular surgery should be transferred to the centralised unit. Local protocols will need to be put in place between each local vascular unit and the London Ambulance service to ensure the safe and timely transfer of patients.

3. Governance

Submission of data to the national vascular database (NVD) for all patients who have undergone arterial vascular surgery is mandatory. Commissioners should ensure that this is added to their contracts with the centralised units.

Every patient that undergoes an elective arterial procedure should be discussed at a multi-disciplinary team meeting prior to surgery. The make up of the MDT depends in part on the procedure and procedure type being undertaken. We would expect to see the most appropriate combination of the following: vascular surgeon, interventional radiologist, vascular specialist nurse, relevant members of the anaesthetic and intensive care team. Centralised units should be audited against this standard.

The service should have a nominated lead consultant vascular specialist to support audit and governance. The service should have a nominated lead nurse with responsibility for ensuring implementation of the Quality and governance Standards. The nurse should also act as a patient advocate.

4. Outcome measures

Using the data submitted to the NVD, units should be monitored and assessed against the following metrics.

Abdominal aortic aneurysm quality markers

Area	No.	Standard description	Target		
			Elective	Unplanned	Emergency
Pre-operative	1	Proportion of patients who are operated on who came in from screening programme?	Monitor	n/a	n/a
	2	Proportion of patients with a known un-ruptured AAA of at least 5.5cms that are declined surgery	Monitor	Monitor	Monitor
	3	Pre-operative length of stay for elective patients to be kept below 1 day average.	1 day	n/a	n/a
	4	On the day cancellation rate for elective AAA procedures	Monitor	n/a	n/a
	5	Number of patients who suffer a ruptured AAA whilst on the elective AAA waiting list	Monitor	n/a	n/a
Operative & in-hospital	6	Proportion of AAA procedures performed using EVAR	60%	Monitor	Monitor
	7	Crude in-hospital mortality rate	4%	15%	40%
Post-operative	8	Crude 30 day mortality rate	4%	15%	40%
	9	Proportion of patients discharged to level 3 critical care/ITU bed immediately following surgery	Monitor	Monitor	Monitor
	10	30 day re-admission rate for patients who have undergone AAA surgery	Monitor	Monitor	Monitor
	11	Total length of hospital stay	Monitor	Monitor	Monitor

Carotid endarterectomy quality markers

Area	No.	Standard description	Target	
			Symptomatic	Asymptomatic
Pre-operative	1	Proportion of patients treated within two weeks	70%	Monitor
	2	Pre-operative length of stay to be kept below 1 day for elective patients	100%	100%
[illegible] e & in-	3	Crude in-hospital stroke rate	6%	3%
	4	Crude in-hospital mortality rate	6%	3%

	5	Proportion of procedures undertaken using a carotid artery stent	Monitor	Monitor
Post-operative	**6**	30 day re-admission rate for patients who have undergone CEA surgery	<5%	<5%
	7	30 day persistent evidence of cranial nerve injury	<5%	<5%
	8	Proportion of patients who return to theatre within 30 days following surgery	<5%	<5%
	9	Total length of hospital stay	Monitor	Monitor

Limb revascularisation quality markers

Area	No.	Standard description	Target	
			Claudication	Critical limb ischemia
Pre-operative	**1**	Proportion of arterial bypass operations compared to angioplasty procedures	Monitor	Monitor
	2	Pre-operative length of stay to be kept below 1 day for elective patients	100%	100%
Operative & in-hospital	**3**	Primary amputation rate (i.e. amputations without prior attempt at revascularisation)	Monitor	Monitor
	4	Secondary amputation rate below the knee (i.e. amputations following previous revascularisation)	Monitor	Monitor
	5	Secondary amputation rate above the knee (i.e. amputations following previous revascularisation)	Monitor	Monitor
Post-operative	**6**	30 day re-admission rate for patients who have undergone surgery	Monitor	Monitor
	7	Total length of hospital stay	Monitor	Monitor

5. Staffing

Those undertaking arterial vascular surgery should be a vascular specialist – not a general surgeon who only performs a small proportion of their work on vascular patients annually. A consultant vascular specialist is a consultant vascular surgeon who has undertaken a minimum of two years final stage training in a recognised vascular unit or who has equivalent experience and who regularly manages patients with aortic aneurysm disease and its associated conditions.

6. Role in the network

Central units would have overall responsibility for coordinating all arterial surgery to take place at the unit, including referrals and transfers from local units. This would also involve coordinating surgeon rotas across the network so they can attend the unit for elective and emergency surgical lists.

It would be the responsibility of the central unit to monitor standards of all vascular services and units across the network. These standards would include:

- Audit data collections and analysis.
- Standardisation of administrative and clinical practices across the network (for example, discharge protocols and intervention strategies).
- Results, analysis and submission of correctly coded data for the entire network to the Department of Health, NHS London (London's Strategic Health Authority) and National Vascular Database.

Commissioning Support for London

Cardiovascular project engagement

A report detailing the responses received on the cardiovascular project during the period of engagement

December 2010

Commissioning Support for London
Stephenson House, 75 Hampstead Rd, London NW1 2PL

Contents

Executive summary

The cardiovascular project undertook a three month engagement period with the public, patients, local authorities and clinicians, including GP commissioners. A key component of this engagement period was the facility for people to comment on the proposals via a questionnaire. The majority of questionnaires were completed online, however paper questionnaires were also made available for people where this was more convenient for them.

In total 201 questionnaire responses were collected. Respondents were asked to complete 16 questions in total. The questions were broken down in a way that mirrored the structure of the full project model of care document, meaning that were an individual disagreed only with one specific proposal they were able to make it clear that that was the case.

The largest single group of respondents were “other healthcare professionals”, making up 54.1% of all respondents. All areas of the model of care received solid support. This ranged from 68.7% of people supporting the recommendations around mitral valve surgery to 93.9% supporting the proposals around the establishment of electrophysiology networks. Overall 83.2% of respondents either “strongly agreed” or “agreed” with the project recommendations as a whole.

The project also received some objections and criticism. These were specifically around the vascular surgery model of care, mitral valve surgery and the service for patients with high risk acute coronary syndromes. In all three cases the comments have been assessed by the relevant workstream clinical lead and the decision was taken not to re-convene the clinical expert panels to discuss the points.

All of the feedback that the project received via the free text sections of the questionnaire as well as those submissions that were written into the project not in the format of the questionnaire are available in the appendix section.

1. Introduction

Following the publication of the updated NHS Operating framework for 2010/11, the cardiovascular project undertook an extensive three month period of engagement. One of the key components of this engagement period was the establishment of an online questionnaire, allowing people to provide feedback directly into the project. In addition, the project team met with pan-London clinical groups, local authority overview and scrutiny committees, LINk groups and other interested groups and parties. A paper version of the questionnaire was made available at these meetings so that the thoughts and views of these groups could be captured in the same format as those completing the online questionnaire. The combined results of both the electronic and paper questionnaires have now been analysed and are presented in this report.

The project also received written feedback on the proposals, not in the format of the questionnaire. These responses are also presented and considered in this report.

2. Developing the questionnaire

2.1 Cardiovascular project summary document

The full version of the project proposals ran into hundreds of pages of text. In order to make the project proposals more accessible a summary document was produced. Those responding to the questionnaire, were advised to read the summary document first to give them the information they needed in order to answer the questions.

2.2 Creating the questionnaire

The online questionnaire was made up 16 questions in all, 12 of which asked for the respondents views on specific aspects of the project. The other four questions asked for demographic data relating to the respondent and one question sought the respondent's views on how the project should be implemented.

Of the 12 questions on the project proposals themselves, ten questions asked the respondent if they agreed with the proposal, with the respondent answering either "yes", "no" or "don't know" in response. If the respondent wanted to add a comment in addition to responding in the way as mentioned, they were also able to do so. The other two questions allowed for free text response, so that the respondent could write in as much or as little as they liked on the proposal.

It was important to the project to have responses that aligned closely with the project proposals, so that if there were specific areas of the proposals that were more or less contentious than others they would be easy to identify. The questions therefore were broken down to reflect each case for change and model of care recommendation.

2.3 Advertising the questionnaire

The publication of the proposals and availability of the questionnaire was advertised widely. Letters were posted to each GP practice in the capital

(around 1,600 letters) containing an introduction to the proposals and details of how to feed back. In addition, emails were sent to over 1,100 individuals. This distribution list included each Local Involvement Network, Local Medical Committees and Chairs of Professional Executive Committees, Council Leaders and Chief Executives, charities, national medical bodies, Chief Executives and Medical Directors of both PCTs and acute trusts, Members of Parliament and the London Assembly. As with the letters to GP practices, these emails contained the web address for the documentation and questionnaire, as well as the registration details for the stakeholder events.

2.4 Paper version of the questionnaire

Following feedback from some LINk groups and members of the project patient panel the project developed a paper questionnaire. This gave two principle benefits. Firstly, it allowed feedback to be captured as and when the project was discussing the proposals with individuals and groups when there was no computer present. Secondly, it meant that people who were unfamiliar or unable to use a computer to complete the questionnaire could also contribute to the project. Having an electronic and paper version of the questionnaire served to increase the number of contributions during the engagement period.

3. Responses to the questionnaire

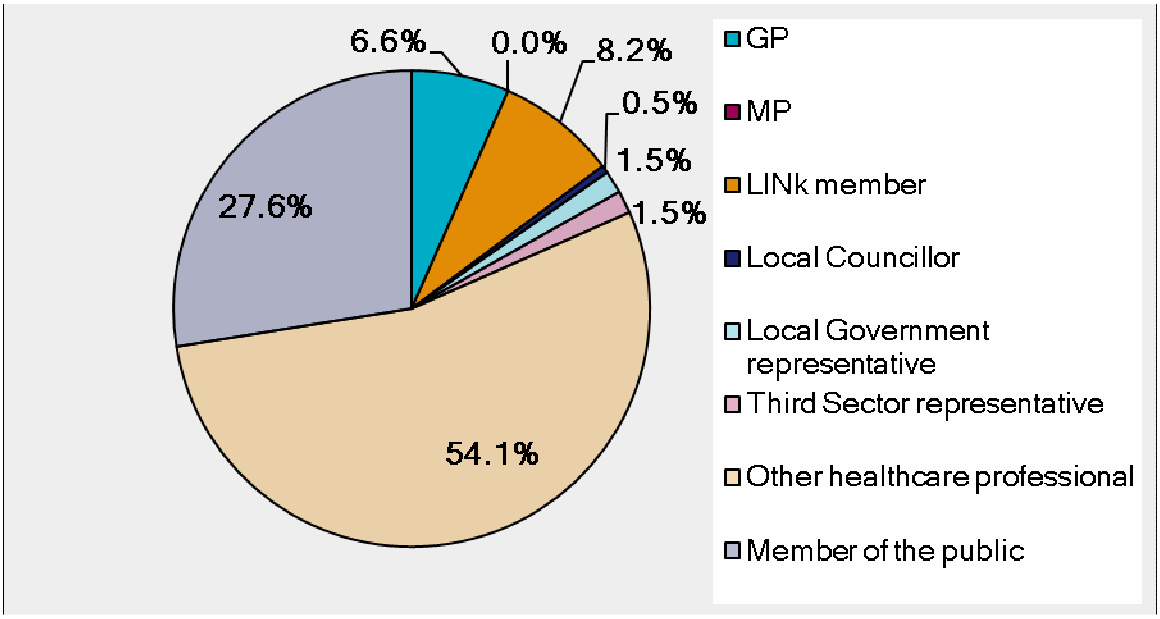
3.1 Overall response rate

Overall the project received 201 questionnaires. 171 of the responses were received via the online questionnaire and 30 paper questionnaires were also received. Not every question on every questionnaire was completed. This means that although 201 questionnaires in total were received, there were not 201 individual answers to every question.

3.2 Demographic details

Responses were received from individuals from over 100 different organisations – the majority of which were NHS organisations based in London. As can be seen in figure 1 below, the majority of respondents were a healthcare professional.

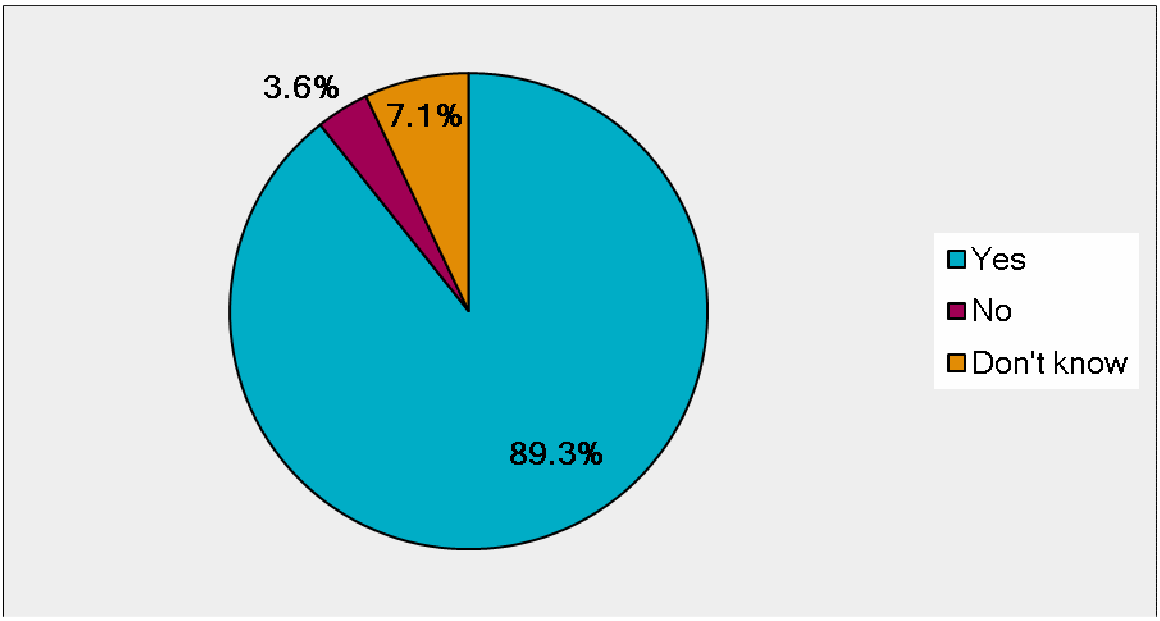
Figure 1. Background/role of respondent



3.3 Responses to questions on vascular surgery

Respondents were asked three questions in relation to vascular surgery. Firstly, they were asked about the case for change in vascular surgery. Responses are displayed in figure 2 below:

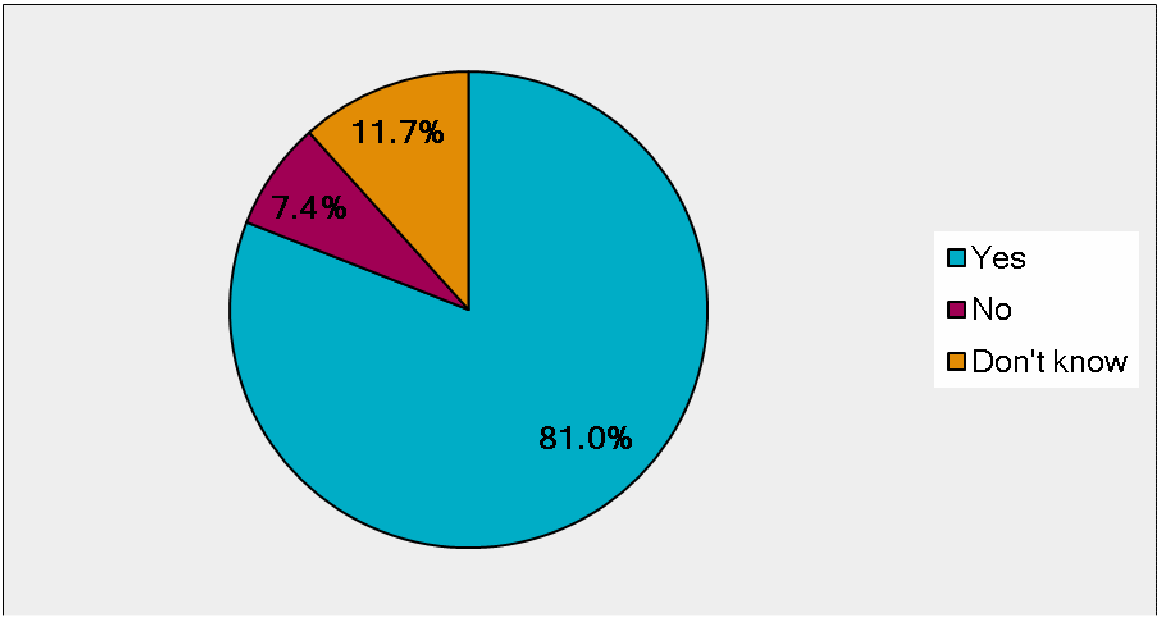
Figure 2. Do you agree that the clinical evidence provides a compelling case for change for vascular surgery?



Secondly, respondents were asked about the vascular surgery model of care, and were specifically asked about the number of arterial vascular sites that there should be

across London. Responses are displayed in figure 3 below:

Figure 3. Do you agree that arterial vascular surgery should be centralised onto five sites across London?

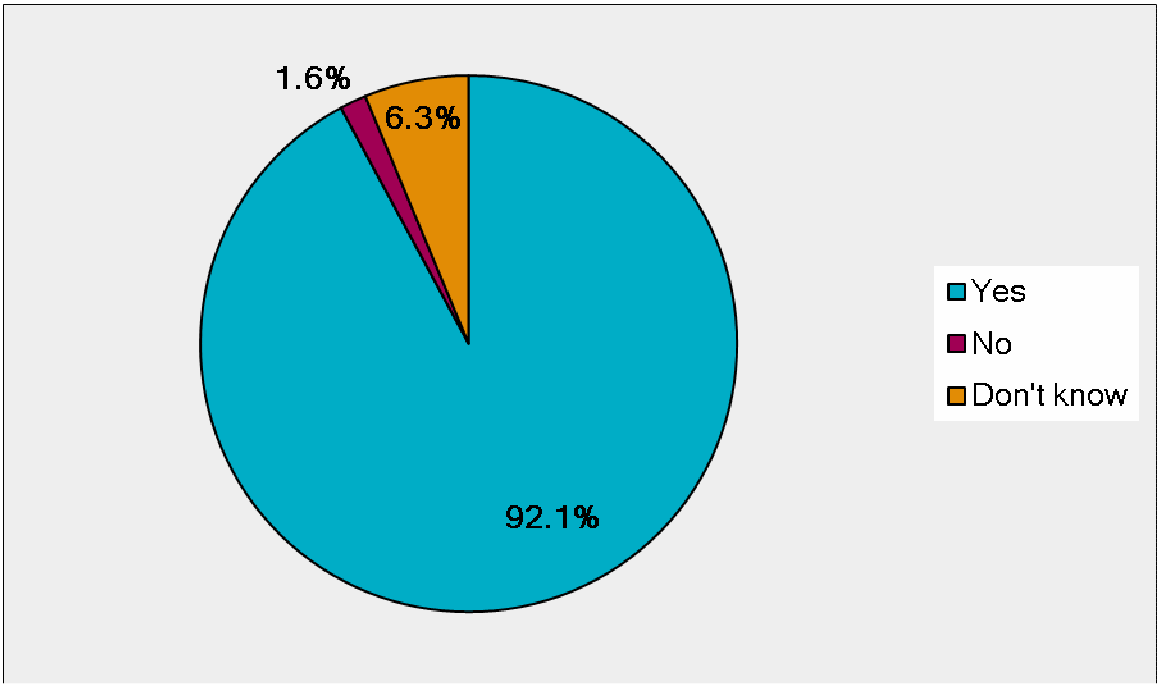


Finally, respondents were given a free text box to write about which services should be provided locally. The vast majority of these responses mimicked what was proposed in the model of care, but all the responses to this question can be found in appendix 1.

3.4 Responses to questions on cardiac surgery

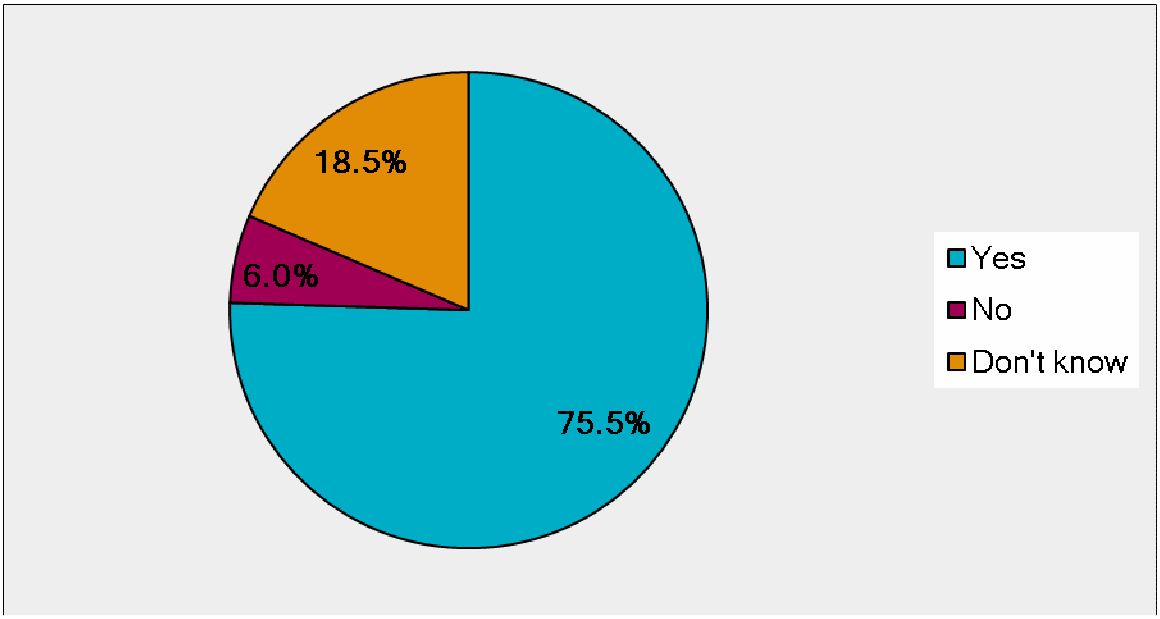
Respondents were asked four questions on the cardiac surgery proposals. The first two questions focussed on the proposed changes to the pathway for patients requiring urgent cardiac surgery. Respondents were first of all asked if they agreed that the service for patients needed urgent cardiac surgery could be improved. The responses are below in figure 4.

Figure 4. Do you agree that services to patients requiring non-elective cardiac surgery should be improved?



Respondents were then asked if they agreed with the use of an electronic referral system and case managers as the best way to achieve these improvements. Results are shown below:

Figure 5. Do you think that the use of an electronic referral system, coupled with case managers in the receiving centers is the best method to reduce delays for non-elective cardiac surgery?



There was then one question asked about the proposed changes to mitral valve surgery and a pan-London aortic dissection service. Responses in these areas are shown on figures 6 and 7 respectively.

Figure 6. Do you agree that mitral valve surgery should be sub-specialised?

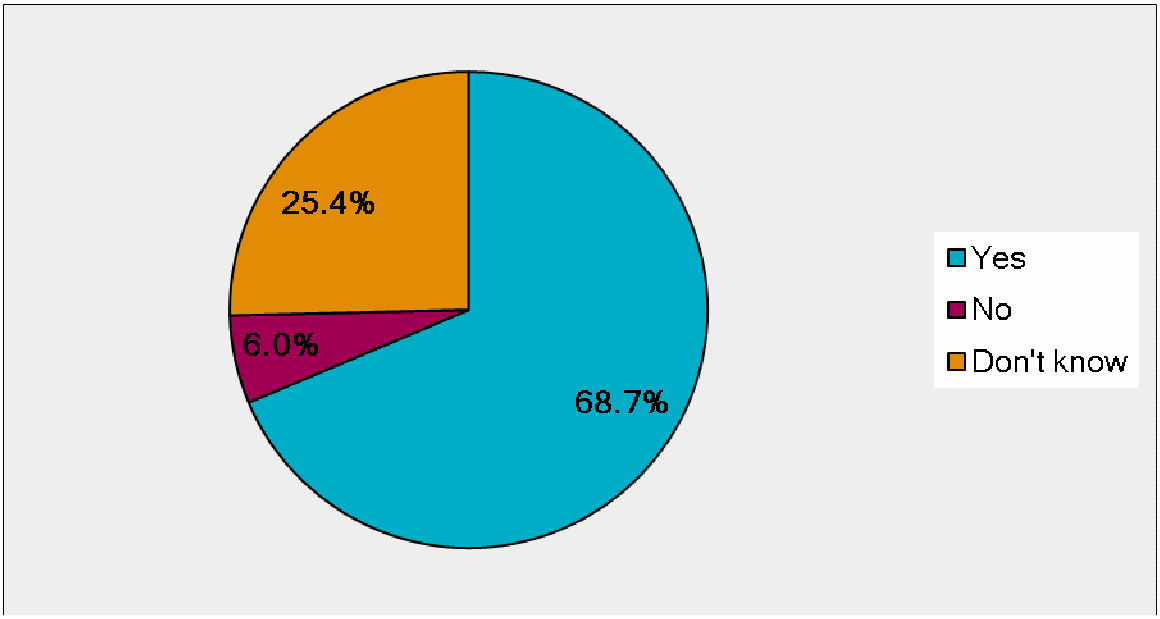
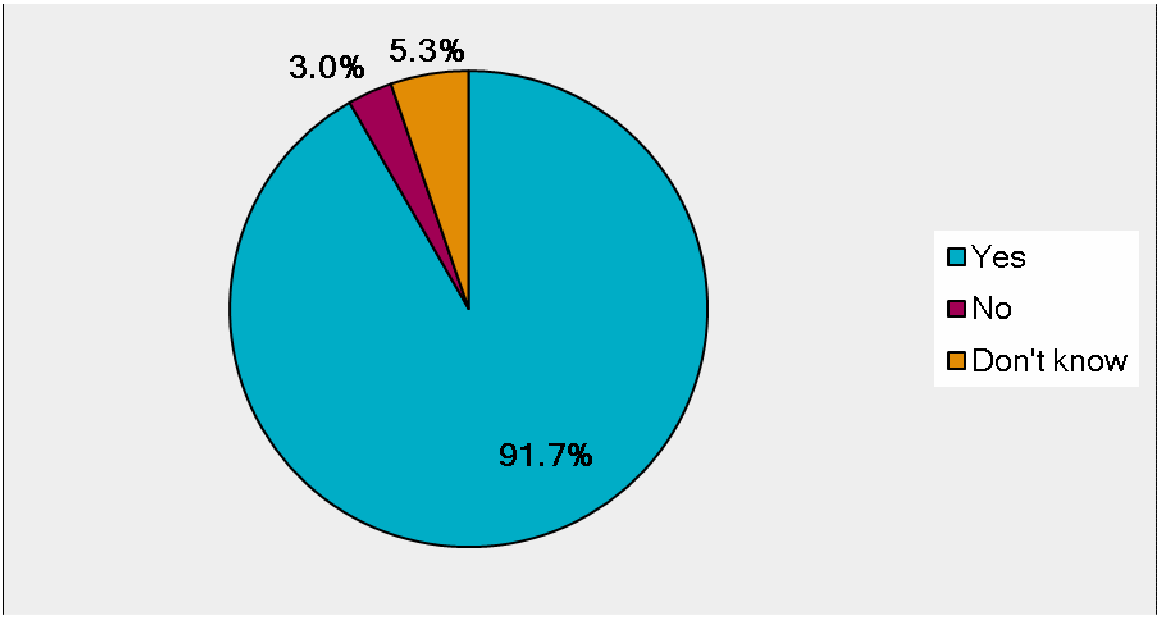


Figure 7. Do you agree that patients requiring surgery for aortic dissection should only be treated at specialist centers by specialist surgeons?

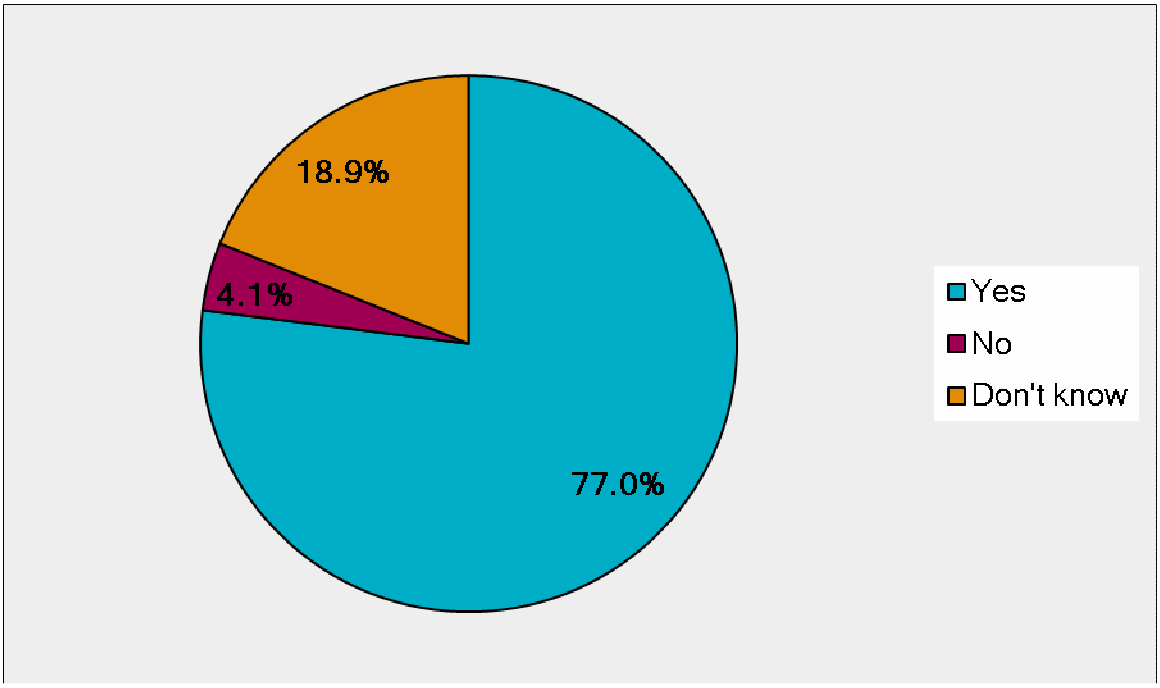


3.5 Responses to questions on cardiology

The questionnaire contained three questions relating to the cardiology section of the model of care; two related to the treatment of patients with high risk acute coronary syndromes, and one related to the formation of electrophysiology networks. The figure below displays the responses to the question which asked for people's opinions on the

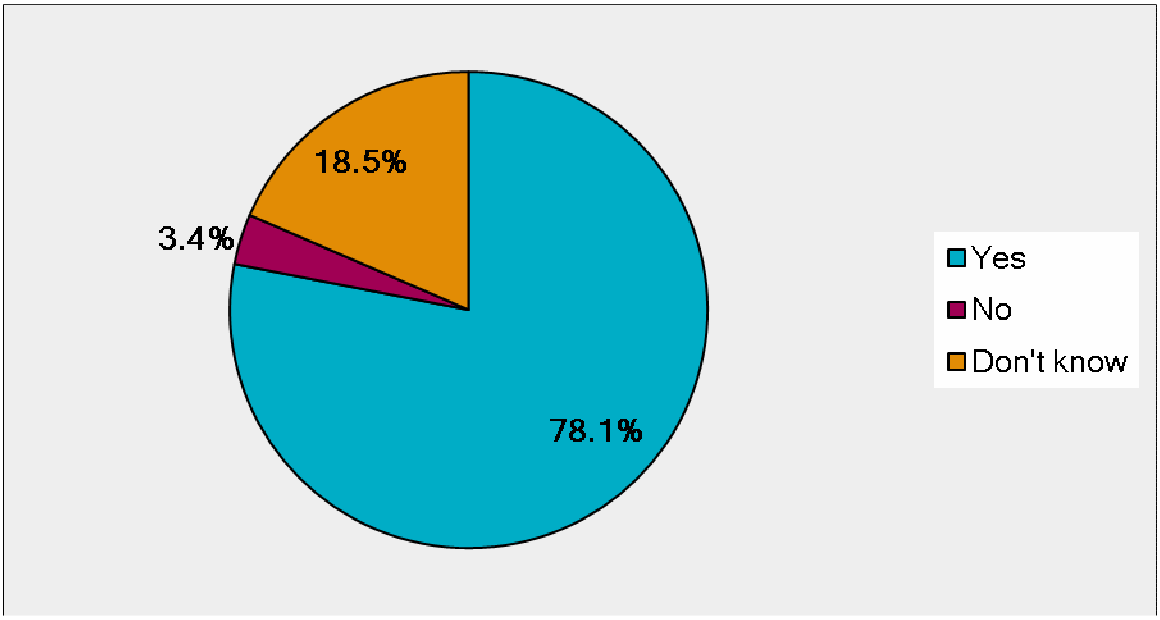
case for change for high risk acute coronary syndromes patients.

Figure 8. Do you believe that services should change for "high risk" NSTEACS patients?



The next question asked if people agreed with the proposed model of care for this cohort of patients. The responses are shown in figure 9 below.

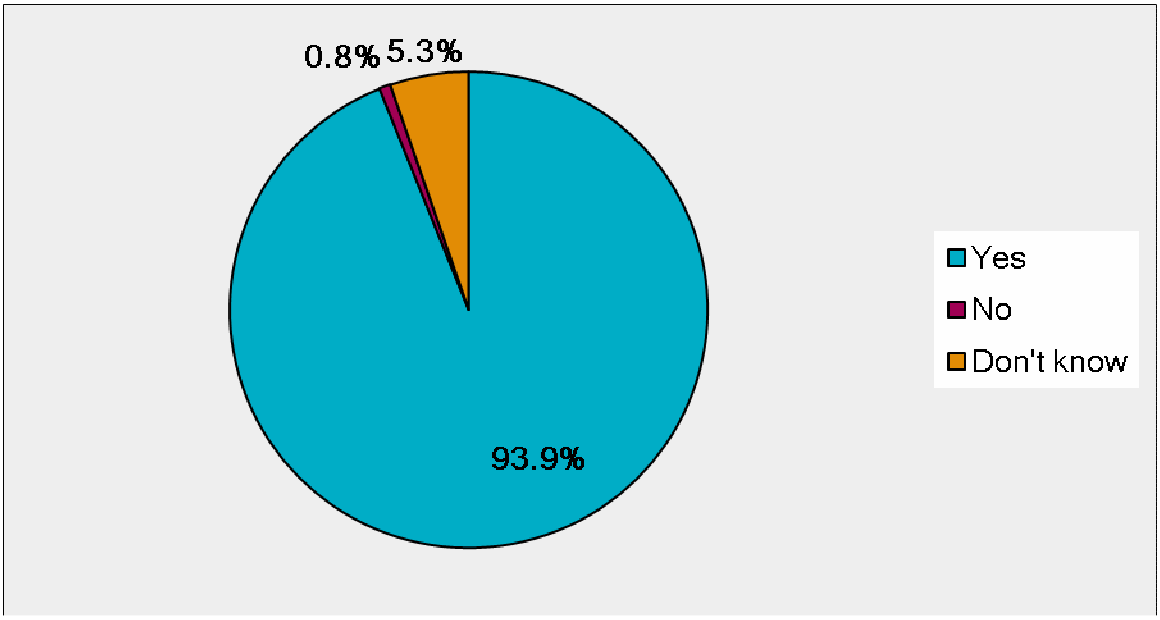
Figure 9. Do you believe the model of care proposed for high risk NSTEACS patients is the right one?



Finally in the cardiology section, views were sought on the proposed model of care for patients with heart rhythm disorders and the proposal to form electrophysiology

networks.

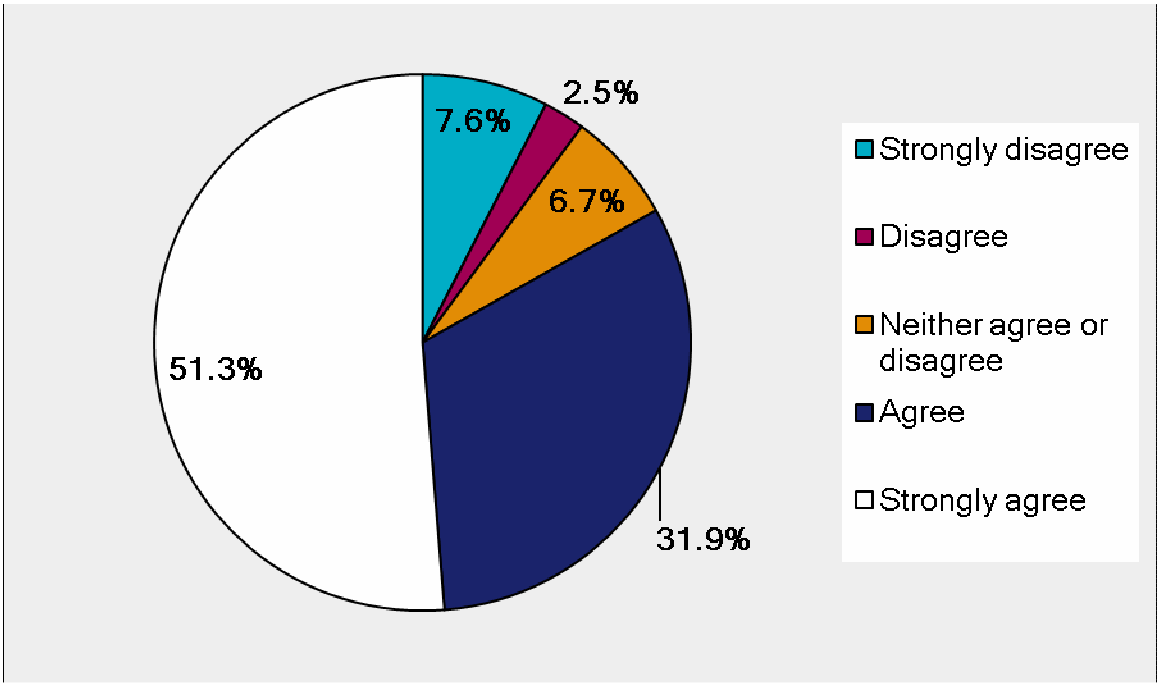
Figure 10. Do you think that hospitals should come together as networks to treat patients with heart rhythm defects?



3.6 Responses to the general questions

The questionnaire concluded with three final questions. One question asked respondents to state how strongly they agreed with the project proposals overall. Overall, 83.2% of respondents either agreed or strongly agreed with the project proposals over all. 10.1% of respondents either disagreed or disagreed strongly with the proposals.

Figure 11. To what extent do you agree with the recommendations of the London cardiovascular service proposals?



The final two questions were free text questions. One asked if the respondent had any more general comments on the project as a whole and the other asked how the person thought that the project should be implemented. The free text responses in these areas were broadly supportive and are published in their entirety in the appendix section.

4. Other formal responses

The project team also received several responses to the project proposals not in the format of the questionnaire. Some of these responses took the form of a letter following up an official meeting where support for the proposals had been agreed verbally and then a subsequent letter was sent to confirm a group's support for the proposals.

Other responses were either posted, or emailed into the project team without any other sort of contact taking place with the project team. The table below shows all the organisations from which a response was received and who did not complete a questionnaire. All of these responses are available to read, in full, in the appendix section.

Table 1. Organisations or groups that submitted a formal response on the project proposals not on a questionnaire.

Organisation or group	Location of full response
Barnet & Chase Farm NHS Trust	Appendix 4

Croydon Health Services NHS Trust	Appendix 5
London Borough of Bexley	Appendix 6
London Borough of Croydon	Appendix 7
London Borough of Havering	Appendix 8
London Borough of Merton	Appendix 9
Londonwide Local Medical Council	Appendix 10

The project also received and responded to a letter from North West London Hospitals NHS Trust in April 2010, when the case for change was first available. This letter, and the response can be found in appendices 11 and 12.

5. Objections and criticism of the cardiovascular proposals

Overwhelmingly, the comments received by the project team were positive and supportive in nature. However there were three areas where the project received some criticism. These were in relation to:

- The vascular surgery model of care
- The sub-specialisation of mitral valve surgery
- The patients with high risk acute coronary syndromes

In each of these three areas, the clinical leads were asked to study the feedback and make a decision as to how to take any comments forward either with the individuals who provided the feedback or to seek comments from the project clinical expert panels.

5.1 Vascular surgery model of care

A letter was received from Barnet and Chase Farm NHS Trust commenting specifically on the proposals to centralise arterial vascular surgery. In essence, the feedback stated that the proposals did not take account of the need for a local service, and that as had been proved over the years at Barnet Hospital and Chase Farm Hospital, it was possible to run a safe local arterial vascular service. The full response from Barnet and Chase Farm can be seen in appendix 4.

The comments from Barnet were sent to the clinical lead for vascular surgery. The decision was taken not to re-convene the vascular clinical expert panel as no new evidence was raised in the Barnet submission and the comments made by the Trust were not from specialist vascular surgeons, but the allied specialties. The project did not receive any comments directly from the vascular surgical team at the Trust. The clinical evidence around the provision of arterial vascular surgery is clear that specialist, high volume institutions result in better outcomes for patients. For that reason it was decided not to amend the vascular surgery model of care.

5.2 Sub-specialisation of mitral valve surgery

In the comments section of the online questionnaire, UCLH NHS Foundation Trust stated that they did not support the sub-specialisation of mitral valve surgery. They stated that the designation of individual surgeons and

teams to perform surgery on the mitral valve was not the best way to improve outcomes in this area. The full comments in this area can be seen in appendix 13.

No new clinical evidence was raised by UCLH and so again, it seems unnecessary to re-group the clinical expert panels. However, the clinical lead for cardiac surgery did agree that strengthening the monitoring of performance of those undertaking mitral valve surgery is something that should be re-enforced with commissioners implementing this work.

5.3 Patients with high risk acute coronary syndromes

The project received a detailed submission from Dr Kevin Beatt (a cardiologist) at Croydon Health Services NHS Trust (formerly Mayday NHS Trust). The submission discussed several aspects of the proposed model of care, had several queries and several criticisms of the proposals. The full submission can be read in appendix 5.

The clinical lead for cardiology has contacted Dr Beatt personally to discuss his comments, and in addition Dr Beatt has been offered a meeting with the project team. It is not felt that the model of care should be revised in light of these comments.

6. Conclusion

Overall, the project received broad support during the three month engagement period, with all but one of the model of care recommendations receiving at least 75% support and most of the recommendations receiving support above 80%. Where the project received criticism the project believes that either comments have been incorporated into the proposals or that they do not mean that the clinical expert panels need to be re-convened to discuss these comments as they are unlikely to change the proposed model of care. Commissioners should proceed with implementation.

Appendices

Appendix 1 - Which components of vascular surgery do you think should be delivered locally?

After care and prevention
Aftercare
All
all should be via centres of excellence
angiogram and PCI
Angiograms & similar
Any follow-up or post-operative care.
Any where the decision to do so would be based on clinically sound, economically viable, 'patient centred' reasons - i.e. not based on local, regional or nationally led political motivations.
Anything done under a local?
As much as clinically safe.
as proposed model
As recommended in report
Below knee amputation by necessity
Care that can be provided safely in primary care
Day case, diagnostic and out patient
Diagnostic tests. Angiography and angioplasty. Venous surgery. Diabetic foot care and management of the complications of diabetic feet. Amputations.
Diagnostics Day case surgery for varicose veins etc. Outpatient services
diagnostics, rehabilitation and clinic visits
Don't know
First consultation, some ongoing care / follow-up in conjunction with specilaist centre
Follow-up care
high volume low complexity work
high volume procedures which are not complex
Initial diagnosis when patient presents but then rapid transfer to specialist unit
Local sites should provide quality local vascular service. This would include outpatients, diagnostics & day surgery for venous procedures.
low complexity, high volume surgery
Low level, high volume day surgery cases that do not require admission to a specialised unit. Non complex and non emergency care.
lower complexity procedures where endovascular techniques can be used
Lower limb varicose vein
Lower risk and less complex cases - hence initial investigation including data on case mix and outcome is important before making sweeping statements and changes.
Minimal risk surgery
need to look at what skills are available in the local area - so not sure
Non-complex once the procedures of limited clinical value have been reconciled. Follow up and rehab should stay local as should AAA screening and outpatients

none
Non-specialist elements
Not competent to answer that depends on volume and expertise on one hand and post op care etc the success or failure does not sole depend on the skills of the surgeon, the MDT has to be in place to maximise outcome
Not familiar enough with the pathway to comment - however it should be whatever is best for the patient, and not what is best for 'the system'
NOT SURE
Not sure.
Only in Ceners of excellence
OPD, venous element of surgery, some diagnostics, ?amputations could be done locally with support from specialists as they can have a long stay and need local services near for good discharge
Out patient clinics, varicose vein treatments (for patients with appropriate indications), some vascular access work (eg day case wrist fistulas under LA), some vascular interventional radiology (agreed at MDT, generally day case), amputation rehabilitation, in patient leg ulcer care (in conjunction with another specialty eg dermatology)
Out patient services Venous services
Outpatient & day surgery for venous procedures
Outpatient clinics Capability for urgent review of inpatients
Outpatient clinics Rehabilitation Some varicose vein surgery
outpatient clinics wound and ulcer care diabetic foot clinics risk factor management varicose vein treatment simple amputations routine angioplasty
outpatient clinics, varicose vein surgery, day case surgery
outpatient tests
outpatients and diagnostics daysurgery procedures
Outpatients and diagnostics etc
outpatients etc
Outpatients, imaging, elective venous surgery, treatment for hyperhidrosis, elective bypass and carotid work if good interventional vascular radiology available on site.
Outpatients, varicose veins, diabetic foot health, wound dressings, rehabilitation
PCA
Possibly angioplasties, carotid, peripheral vascular
Pre-op investigations, post op suture removal, follow-up for complications
Screening, counselling, rehabilitation
Simple non complex that are able to be delivered without significant infrastructure and with a high enough critical mass for operators to be proficient and to make sure that outcomes are of appropriate standard.
Simpler vascular work such as vein stripping etc but large, specialist surgery should be delivered from a specialist centre with highly specialised staff available.
The most useful parts.

Those procedures that do not require specialist knowledge, surgical techniques or technology. Procedures as specified by your documentation that make up around three-quarters of all vascular surgery could be provided at the local hospital but those that are performed rarely require specialists who are trained in the latest techniques, and have access to the latest tools. It is common sense - you would never ask a mechanic to fix an aeroplane - yes they are both vehicles but one you need specialist knowledge that mechanics just don't get exposure to everyday.
Those which are done enough to provide appropriate outscomes
Varicose vein surgey duplex scanning out patients rehabilitation & amputee rehab
varicose veins
Varicose veins
Varicose veins, vascular outpatients, vascular diagmostics, potentially below knee intervention
vein surgery
Veins.
With regard to the delivery of services, the committee would want to take advice from specialists.

Appendix 2 - Are there any further comments that you would like to make on the proposals as a whole?

a time frame for implementation is needed
a very good piece of work
Another top down approach rearranging the deck chairs. The variation in outcome measures is deplorable but it is a matter for the RCS and PDP of CV surgeons not an excuse for re-organisation
As more and more specialised services accumulate in the same hospitals there will be severe stretch on ITU capacity. There is also likely to be a paucity of skills and services at DGH level. There may also be an additional impact on A&E
As said before electronic systems are only efficent when properly used and from experience this is always breaking down due to bad referral
Best of Luck!
Cardiac networks are the best way to ensure consistency and excellence
I hope the chage of government does not deraile this important clinically and patient led initiative which is long overdu
I hope this is progressed very quickly and applied to all areas, but especially those with current poor performance
I think that the new model for cardiovascular surgery will improve the way surgery is carried out for those patients who require it, in terms of shorter waiting times, shorter bed stay and having it done by a surgeon experienced enough to do so, hence improving and prolonging patients' lives. It makes alot of sense.
I would like to have seen cardiac prevention and rehabilitation inluded in the care of patients post cardaic event. This is an evidence based part of their treatment and care which inproves quality of care and life.
It can be difficult if certain on site co-dependencies are made absolute as this is an easy way to block change. It is perhaps preferable to preface interspecialty working with a statement that certain on site codependencies are strongly recommended but in their absence there should be adequate arrangements for rapid opinion/investigation/transfer etc. An example is Stroke services which may have multiple localities feeding into one vascular unit providing carotid intervention.
It's all been said.
Make sure that all the paperwork for the patient is available prior to any surgery
My comments are in relation to Vascular Surgery only. The proposals are entirely in line with; evidence, national guidance, efficient delivery of services and common sense. The key is to ensure that robust protocols are in place to; maintain support for 'spoke' providers and ensure patients are dealt with equally regardless of location.
no
No
no
No
No thanks
NO. Great work done. It is normally helpful to include the codes of data extracted. A very useful set of reports.

please include the relevant therapists on the pathway including dietitians and physios
Specialisation of services is proven to produce better outcomes - this has been the case with heart attack patients, stroke and major trauma.
The Adult and community PDS Committee supported the proposals presented at the meeting on 21 September 2010 and were impressed with the case for change that was presented.
The idea that hospital units should work together is both logical and well overdue. Avoid centralised referral centres, allow local specialists to refer within their network, this way you integrate the service.
The LINk supports the general principles proposed but cannot fully comments without detaled proposals. [The devil is always in the detail!]
The network is committed to the roll out of the programme.
The proposals look very good, however if they are to be implemented, I feel that excellent pathways and systems of communication will be essential to the success of any changes. Communication between the Drs on the teams at the local and central hospitals, but also the allied health teams will be important, specialist nurses, rehab teams... Recovery following vascular surgery and heart problems is not soley dependent on the quality of the care received from the Doctors, Surgeons and inpatient staff, but also on the quality of communication between the supporting teams at the local sites as well as in the specialist sites. Otherwise teams supporting the recovery of these patients will be inadequately supported, and therefore quality of care will be lost.
The review should have looked at some of the models already in existance.
There is no infrastructure for the vital work of cardiovascular research, clinical trials, registries, audit and data tracking which should also be partly centralised. There is little scope for cardiac rehab and prevention which is equally as important to the entire cardiovascular proposal for London. I'd be happy to present more details of these key shortcomings which have major clinical outcome and financial implications. A more encompassing proposal would attack what matters as equally to patients - pre-care: prevention, aftercare: cardiac rehab and high standards: research and audits!
These proposals have obviously been thoroughly researched and tested against best practice and amongst clinicians and patients. You are to be commended for such a sensible and easy to understand proposal that puts quality outcomes above the common irrational and outdated mindset that the local hospital should deliver all care.
This all sounds vey good. I hope it will not result in the reduction of ou excellent NHS staff but that we will see an improvement for all concerned
This is a good thing. How are gaps in general surgery rotas going to be filled when general surgeons with an interest leave general surgery. How are we going to ensure hospitals co-operate when PCTs & SHAs are stopped
We need to move forward with these proposals in a timely manner as we have already upgraded the services for stroke and trauma.
We should be doing everything we can to care for people with illness.
What are you waiting for? For the patients' sake don't wait for the politicians.
Whilst trying to achieve excellence it is very important to try and achieve continuity of care. The patient always appreciate seeing "someone" who knows them. The conveyor belt system does not help their psychological need though it may have the best clinical outcome.
Would be worth reiterating why this is special for London - its density and relatively small are (compared to regions) make this a viable option

Appendix 3 - How would you like to see the recommendations of the cardiovascular proposals implemented?

A combination of network/CSL and commissioner input could easily take this forward.
All these proposals must be undertaken in the wider context of reconfiguration across multiple services so that system change can occur as smoothly as possible. The populations served by these services will expand beyond consortia so cardiac networks will have to take a strategic overview assisting consortia to generate consensus and create pathways for the entire local population not just their patients.
As much information as possible being made available to patients through local PCT's.
As quickly as possible
As quickly as possible before we all lose our jobs!
as quickly as possible via a workable system not PCT who seem to have tiers of management doing nothing but attending one meeting after another to no avail for years.
As soon as possible
As soon as possible and with steady gradual conversion over a fixed time frame with clear milestones and performance targets for clinical outcomes
as soon as possible with full ppi involement
as soon as possible. London is the lead centre for reconfiguring change in vascular surgery services in the UK. We cannot carry on delivering haphazard models of care in the modern era. To me, the volume outcome relationship is compelling.
ASAP with with clear injstructions to those unit who are not committed
ASAP. Trusts and commissioners need to get together to start the process of developing the networks.
Bit of an odd question - not being a specialist in this area I don't think I'm qualified to comment but I don't believe that GPs, who don't have the knowledge of these services and who have a vested financial interest in how services are commissioned, should be responsible for their implementation.
By joined up commissioning and collaboration between providers as networks
By urgent action across London and especially urgently in poor performance areas
Consult all stakeholders. Determine curent state. Propose future state. Agree the transition plan and implement
Driven by informed commisioners and patient groups
each inner London hospital/hospitals should be assigned a team with the expertise to conduct one or more procedures, and should maybe commence with two one or two hospitals at first to pilot and then roll out to other hospitals.
gradually with sufficient resources and support to facilitate a smooth change and to enable effective and sufficient communication.
I believe that cardiac networks are in the prime position to undertake the implementation; in London cardiac networks expanded to become cardiac and stroke Networks and have proved successful with the implementation of the stroke agenda, they are firmly established and well positioned to understand the implications of the changes and work with clinicians and managers to ensure quality services are established and maintained.
I would not

In a coordinated way to promote equality of access and improved qualityn i.e. local implementation via Networks.
In a timely and cost efficient manner. They should be implemented as soon as possible so as to not lose momentum and risk nothing being implemented at all.
In full!
In planned stages
its difficult to see how gps can individually have a pan london perspective. therefore, either a group of gps that are mandated to act on others behalf or another pan london group.
On BBC News, standardised memo across the NHS Network, GP's and Department of Health,
Presentation to a day long meeting of as many London clinicians as available to discuss strategy and short-comings
Quickly
Quickly and effectively!
Quickly and safely, with the full involvement of relevant stakeholders.
Quickly with cooperation between NHS London / GP commissioners and trusts.
Rapidly with effective clinical governance and regular review of designated centres
Rapidly, with as little bloodshed as possible
sector based coordination between patients, commissioners and providers
The most imortant factor will be good communication and agreement across the organisational boundaries on the individual patient pathways (i.e person centred)
These comments are regarding Vascular services only: I beleive they should be implemented fully and with no hesitation. The changes should serve as a catalyst to promote similar changes, where appropriate, accross the UK. Understandably there is much resistance to change on the subject of vascular surgery and UK patients outside London deserve equally good services. The London configuration should be used as a benchmark for other areas.
These need to be project managed with appropriate project management infrastructure. Cardiac Networks can play a role here with involved centres to make sure that all key stakeholders are involved and know what is going on. This process needs to make sure there is not duplication and commissioning groups need to link with networks to make sure financial flows are planned correctly.
They should be implemented ASAP. The various (Cardiac, Stroke, Vascular) local and pan London networks are probably the key to role out. If a Network has experience of any of the models of care, this should be shared with the other Networks.
Through the Cardiac & Stroke Networks who are ideally placed to do so.
Unfortunately unable to access documentaton so could only answer by what patients have told me.
Unsure
will require education acceptance of clinicians and patients leave alone politicians. the case has to be made at every DGH and among commissioning groups. Need to link with better care closer to home so that this doesnt come across as a centralisation agenda. networks need to establish their independance from institutions and individuals - the providers. who will believe that this is about improving out come and not cutting back services in certain hospitals good luck with the implementation.
with care not to quickly
With consideration to all involved staff and patients, to the best possible outcome

With immediate effect and without interim steps - these are likely to become sticking points
With immediate effect.
With much public and patient involvement and education information on reasons for change.
Yes, with changes

Appendix 4 – Response from Barnet & Chase Farm NHS Trust

Barnet & Chase Farm NHS Trust Response to London Cardiovascular Services Model of Care

The Barnet & Chase Farm NHS Trust has read this document with interest and concern. Whilst we are obviously in complete agreement with the requirement to see improvement in the quality of care offered in this field across London we, as a trust, do not believe that this will be achieved to the maximum degree possible using the model presented in this document. In the view of the trust quality of care is made up by a number of criteria including equality and speed of access, the skills and technologies available, case numbers and certain interdependencies as recognised within the document which latter however largely apply only to a relatively small number of super-specialised cases. However a truly excellent service must also take into account the requirement for local access. The majority of our patients requiring intervention are elderly and although it is often claimed that all patients will be "prepared to travel for an improved quality of care" it is surely the hallmark of a service of true excellence that patients should wherever possible be able to access such care locally. The proposals presented appear to serve better the requirements of central institutions and clinicians than those of the majority our patients. In the view of the trust it is regrettable and indeed notable that the clinicians selected to undertake this review are all representatives of central institutions and it is perhaps the case that has lead to a failure to appreciate the value which our patients place upon an excellent local service.

Within the Barnet and Chase Farm NHS Trust all vascular surgery has been undertaken for many years by a team of four specialised vascular surgeons together with a team of five specialised interventional radiologists. We have been early to embrace technological change and have an extensive angioplasty and EVAR programme with excellent outcomes documented. In particular it should be noted that there have been no deaths or serious morbidity within our EVAR series clearly demonstrating the safety of advanced technologies introduced into a large district hospital vascular unit with appropriate governance. The Trust also performs a significant number of angioplasties each year with good outcomes for patients. It is unfortunate that the report chose to use data from the year of introduction of the NHS integrated PAS system into the trust. As has been widely found the "teething problems" associated with the introduction of this system lead to considerable difficulty with the production of accurate activity data and that presented within the document significantly under presents the activity of our vascular surgeons. An up to date set of figures for the unit is appended (appendix 1).

The trust is committed to ongoing development in its vascular surgical services and has for example successfully taken on the challenge of a rapid access carotid endarterectomy service for its stroke patients. Whilst the trust has to date operated an in patient acute vascular surgical service on both sites it is presently in the process of moving acute in patient services onto the Barnet site so that it is completely co-located with the newly equipped interventional radiology suite. The trust has for a number of years provided a 24/7 emergency vascular service from within its own resources, but recognises the need to collaborate with other partner trusts to

achieve a satisfactory service across North London and is collaborating with the North London Vascular Service.

The trust also feels that this review has completely failed to appreciate the very significant contribution which its vascular surgeons make to the other specialities within the hospital which seek their advise and support on a daily basis including for example diabetic management and orthopaedic surgery, as well as the support provided to colleagues undertaking other forms of major surgery within the organisation. In this regard the contribution of the B&CFH as the major provider of surgical cancer care within the North London sector must be appreciated.

As stated at the beginning of this response the trust appreciates the need for a small number of patients with particularly complex vascular problems to be treated in a centre with cardiovascular co-dependency. In the experience of our vascular clinicians it is the case that these cases can be identified at an early stage in their investigation and transferred to a appropriate provider with no evidence of any detriment to the patient. The trust would as such wish to work as part of an extended network , but is forced to point out the difficulties attendant on the transfer of patients to the central London centres owing largely to capacity issues and sees no immediate or indeed medium prospect of a change in this circumstance particularly if this centralisation agenda is pushed ahead. Delays caused by these problems with patient transfer, which are apparent to the trust in fields aside from vascular, give us as an organisation little confidence in the ability of a centralised project to produce a responsive service, whilst the possible transfer of post procedural patients back to a deskilled periphery is we feel a recipe for deteriorating outcomes. The experience of the trust in “hub and spoke working” does not bring us to the conclusion that this model maintains highly skilled personnel in the periphery, indeed rather the opposite, as understandably senior clinicians are attracted to the major centre. It is the view of the trust that if this agenda is taken forward it will be increasingly difficult to maintain essential skills to deal with patients inevitably referred back from the centre and to undertake the myriad other tasks undertaken by our vascular colleagues within this large surgical centre. In addition it is likely that it will be increasingly difficult to attract good candidates to posts at all levels within the service.

Appendix One: Total number of procedures carried out at B&CF in 2009/10

- 39 AAA repairs – 30 EVAR and 9 open repair procedures
- 60 carotid artery surgery procedures - 57 Endarterectomy procedures, 0 Carotid Angioplasty and Stenting and 3 Carotid Artery Surgery
- 82 angioplasties

London Review - cardiovascular services:

Appendix 5 – Response from Croydon Health Services NHS Trust

Proposed model of care

The Stated goals of the model of care are:

- Saving more patients' lives
- Increasing the speed and equity of services
- Improving patient access
- Reducing the length of time spent in hospital
- Meeting unmet needs
- Improving the use of new technology and research
- Making the best use of NHS resources and saving public money.

For patients with Coronary artery disease the following are recommended:

1. Patients with STEMI should be treated with angioplasty at Heart Attack Centres.
2. Patients with NSTEACS should have access to coronary angiography and for patients deemed to be at, "high risk" this should be done within 24 to 72 hours.
3. The proposed model of care recommends improvements to streamline the current patient pathway. The new pathway will:
4. Diagnose and risk stratify patients early
5. Manage patients according to their risk level through the use of an agreed evidence- based risk stratification tool
6. Ensure that "high risk" patients are offered angiography within 24 hours of admission.
7. If the patient is triaged in a hospital that cannot provide angiography within 24 hours, then the patient should be transferred to a unit that can. Units wishing to provide this service should ensure that they are able to offer angiography on a seven day basis and provide commissioners with evidence of weekend working as required.

1. Treatment of STEMI patients

The model for the treatment of STEMI patients was set up in London in 2001 and this

has been adopted as a national standard. The London ambulance service in delivering patients to a heart attack centre is exemplary, particularly when one considers the size of population.

The service provided by tertiary centres is variable with some units incurring unacceptable, “time to treatment” delays, and there is an additional problem with tertiary units declining to accept questionable patients who do not fit the strict criteria for STEMI transfer, but who benefit from the early interventional strategy.

The service is also compromised by physicians at many DGHs who fail to make the appropriate diagnosis or do not do so within the acceptable time frame. In both cases the root of the problem can be traced back to a lack of expertise at the patient interface.

2. The treatment of patients with non NSTEACS

2.1. High Risk NSTEAC

The treatment of high risk NSTEACS has become confused because there is no clear definition of a, “high risk” patient. In the review the criteria incorporates a broad range of patients including many patients who are not at “high risk”.

It should be clear that only a very small number of patients with NSTEACS (< 1% of patients with acute chest pain) are truly at high risk, to the risk level of a STEMI patient who needs early intervention within the stipulated time frame. In the presence of an insufficient data this group can best be defined as patients with:

- Persistent or recurrent angina with ST- changes (2mm) or deep negative T waves **resistant to anti-anginal treatment**.
- Clinical symptoms of heart failure or progressing haemodynamic instability.
- Persistent life-threatening arrhythmias (VFI VT) unresponsive to treatment.

The diagnosis of high risk NSTEACS as defined by the above criteria cannot usually be establish at first presentation because the criteria defines patients who have failed initial treatment. In this situation, when the risk is difficult to define it is not possible for any useful risk stratification to be performed in the ambulance.

Should patients subsequently develop clinical features that would demand an early intervention there should be systems in place which will allow them to be treated in the same way as a STEMI patients with a critical care transfer to a centre that provides a 24 hour interventional service. This would mean broadening the indications for immediate interventional treatment.

In the context of medical admissions any NSTEACS could be considered “high risk”, but in the context of NSTEACS patients only those who fit the above criteria should be classified as high risk.

The review makes a case for considering moderate or low risk patients for the same treatment

as higher risk patients. However, there is currently no data to suggest that NSTEACS patients benefit from earlier treatment and there is some data to suggest that it may be harmful. Almost all of the clinical trials in this

area compare interventional treatment within the first 48 to 72 hours with later in-hospital treatment or treatment post discharge, without specifically scrutinising patients who present within the first 24 hours. The recent ABOARD study which compared patients treated early to those treated the following day showed a doubling of the myocardial infarction rate in the group treated early (p=0.09). There was no advantage in any clinical outcome for those treated early, but there was a reduction in inpatient stay.

Currently there no indication for the immediate transfer of patients to a centre with a 24 hour interventional service when first assessed by the ambulance service or first assessed in the casualty department.

The review should have clearer risk stratification documentation of the NSTEACS patients.

Review statement:

> *Diagnosis and risk stratification may be possible by ambulance paramedics in future.*
>
> *At present, ambulance services are unable to carry out the required assessments to*
>
> *diagnose high risk NSTEACS patients due to lack of equipment and appropriate*
>
> *clinical training*.
>
> *Proposal*
>
> *High risk NSTEAC patients should be treated in the same way as STEMI patients with critical care transfers to designated Heart Attack Centres*.

Response

There is no data to support this proposal nor does the London review provide any.

Review statement:

Assumptions

The financial modelling for NSTEACS patients makes a series of assumptions. Where this is the case every effort has been made to be conservative in the estimate and give a worst case scenario.

> *The implied assumption throughout the paper is that the number of patients who currently end their pathway with a non-elective PCI will be the same number of patients who in future will be triaged as high risk. This assumption had to be made to allow for a comparison between what is happening currently and how the proposed new pathway will affect this. The implied assumption throughout the paper is that the number of patients who currently end their pathway with a non-elective PCI will be the same number of patients who in future will be triaged as high risk.*

Response:

> I do not believe there is a basis for this statement for the reasons given above. Many non-elective PCIs are performed because the

patient is in-hospital and having an invasive investigation; indicated because the diagnosis is uncertain. In this situation there is the option to proceed on to a coronary intervention. This practice is common and cost effective for the provider because it avoids a separate procedure. It is also convenient for the patient who is able to receive definitive treatment at the earliest opportunity. It allows an earlier return to an active lifestyle and an early return to work. However these patients are not at high risk and many of them will have a risk profile similar to those who have chronic coronary artery disease.

A revaluation of the financial modelling should be performed with a more appropriate definition of higher risk patients.

2.2. Non "High Risk" NSTEAC Patients

Review Statement

Case study: North east London pilot

The proposed model was piloted in North East London between November 2007 and January 2008 to assess the feasibility of early transfer of high risk NSTEACS patients from an emergency department to a receiving PCI centre. The pilot was undertaken at Newham University Hospital NHS Trust and Barts and The London NHS Trust (Royal London Hospital). Once risk stratified, patients diagnosed at these hospitals with high risk STEACS (based on locally pre-determined criteria) were transferred to the London Chest Hospital. Over 800 patients with suspected acute myocardial cardiac ischaemia were assessed in the two emergency departments. Of these, 11% fulfilled all the criteria and were confirmed as high risk NSTEACS. These patients were treated on the pathway, which involved immediate medical therapy followed by ambulance transfer to the London Chest Hospital for possible PCI.

The north east London pilot data demonstrated that for those patients assessed as high risk NSTEACS, the mean time from entering the emergency department to transfer was 3.5 hours. This comprised 37 minutes to be seen at the emergency department, 88 minutes 'process' time, and 78 minutes waiting for the ambulance transfer. Coronary angiogram was performed an average of 12 hours after presentation, with a revascularisation rate of 65% in transferred patients. This compares favourably with the rates of revascularisation in randomised controlled trials of early revascularisation in NSTEACS. This pilot study demonstrates that earlier transfer of patients is feasible and that shorter treatment times can be achieved. Further work would need to be undertaken.

Response:

Although the above data is not published or peer reviewed it does provide an interesting insight into the problem of differentiating patients with diagnosis of NSTEACS from those who do not have acute cardiac ischaemia.

Of the 800 patients assessed in casualty 11% met the criteria for NSTEACS with a high enough risk to be considered for early transfer to a heart attack centre. Of these only 60% needed revascularisation. Data from clinical trials would suggest that only a handful of these patients would have needed early intervention, within the first 24 hours, with the vast majority safely undergoing intervention within the first 48 to 72 hours. It is presumed that in 40% of patients the diagnosis was incorrect reflecting the well recognise problem of inexperienced doctors in casualty departments failing to

make the correct diagnosis in patients with acute cardiac ischemia.

This is a problem that is well recognise by those who treat acute cardiac ischemia, particularly in the context of treating STEMI patients and represents a lack of clinical expertise by junior doctors who are usually the first contact for patients admitted acutely. From the original 800 patients presenting only 53 (7%) needed early intervention, but not necessarily intermediate intervention. Furthermore, filling tertiary centres with patients who don't need to go there will only further delay the transfer of patients who are already waiting for tertiary centre treatment, particularly cardiac surgery.

Working on the assumption that a good proportion of patients who do not need intervention will need an invasive investigation in order confirm that there is **not** an acute coronary problem and this number might be as high as 10 to 15 per cent of the patients presenting with chest pain, there is still another 640 patients (80%) who will have to be a properly assessed, the correct diagnosis made and optimal treatment given. The review does not give sufficient consideration to the management of these patients or to the cost of treating them.

It should be clear that any development based on the North East London model must be flawed.

Review Statement

Additionally, it is envisaged that a proportion of patients currently admitted to a hospital with undifferentiated chest pain and then discharged home without intervention would be triaged in A&E and discharged to their GP without being admitted. This will result in reduced hospital admissions and costs.

Response

The Review recognizes that that problem exists but there is no indication of just how important a problem this is, nor is there an indication of how difficult it is to deal with these patients efficiently. Although early discharge is advocated there is no indication of just how this should be achieved in those patients who have no evidence of acute cardiac ischemia.

The first point to appreciate is that the diagnosis of non-cardiac chest pain is not always easy to make and perhaps more importantly it is often a diagnosis that the patient finds difficult to accept. Inexperienced doctors who are not confident to make a diagnosis are more likely to admit patients unnecessarily and should they discharge patients, anxious that they may have a serious cardiac condition there is a high incidence of readmission.

The problem is compounded by the lack of insight into the prevalence of false positive troponins in a variety of conditions, including chest infections, other inflammatory chest conditions, heart failure, pulmonary embolus and compromised renal function. Patient pathways which over emphasise the importance of positive troponins only compound the problem.

The cost to the health service of dealing with non-cardiac chest pain is unknown but it is clearly substantial. It is also unsatisfactory for

the patient because there is often a delay in obtaining a timely and proper opinion and the burden of experiencing symptoms that are not adequately explained can be a considerable for many. In many cases the most expedient course is to performed early angiography, particularly for those who have known coronary disease but are not thought to have an acute problem.

The issue is relevant to both tertiary centres and referring hospitals and is particularly relevant to be busy casualty departments

The difficulty in dealing with this group of patients has been well recognised for many years and was one of the principal considerations when setting up the Mayday model. (see below).

Cardiologists may not be fully aware of the problem because they did not come across the patients who are usually assessed in casualty and then admitted under the admitting Physician rather than a cardiologist.

3 Delays in transferred to tertiary centres.

Over the past 20 years there has been a failure to appreciate the cost to the Health Service of patients waiting for transfer to specialised centres. There has been little incentive for these well financed centres to provide a more efficient service as there is no financial advantage in them doing so. On the other hand, the referring hospitals with the least resources have had to cover the cost of patients waiting for transfer, a wait that has no clinical advantage with an excess cost they are powerless to influence*. Individual DGHs still have to cover the cost of hundreds or even thousands of unnecessary bed-days each year, incurred through patients waiting for cardiology transfer alone.* Some centres have improved their service in recent years, but most centres still operate services that are inefficient and centred around the preferred working practices of medical and nursing staff rather than the needs of the patient. Waiting lists and delays in providing definitive treatment have been entrenched in the NHS from its inception. This review has the opportunity to make a statement of intent that recognises the problem and aspires to emulate the most efficient of Health Services.

Review statement:

☐ *The average total pathway length for patients needing urgent CABG should not exceed 21 days.*

☐ *The time between admission to the patient's local hospital and referral to a surgical unit should not exceed five days.*

☐ *The time between referral and transfer to the surgical centre should not exceed five days.*

☐ *The average length of stay at the surgical centre should be 11 days or less.*

The reviewers acknowledge that the above recommendations are less than optimal.

There can be no good reason for recommending such excessive times and the numbers should be dramatically reduced.

A more appropriate recommendation would be that the total delay for the CABG pathway should not exceed 10 days and the time between referral and transfer should not exceed 2 working days.

3. The Mayday model for the treatment of acute coronary syndromes.

In 2005 Peter Stubbs and I set out to make radical changes to the Mayday cardiac services. The goal was to develop a model for treating cardiac and non-cardiac chest pain which was evidence-based and cost effective in the same way that we had developed the model for the treatment of STEMI patients, now adopted as the standard throughout the UK. The 7 point stated goals of the London review could be used as the stated goals for the Mayday model. To achieve those goals it was determined that we should provide:

1. A service that gives patients access to specialist advice at first contact
2. Access to all essential cardiac investigations on the day of admission
3. Invasive investigation and treatment within 24 hours of admission as appropriate
4. A coronary care unit and adjacent “cardiac zone” where all cardiac patients could be admitted and looked after by a consultant cardiologist, dedicated cardiac medical staff, trained cardiac nurses and technicians.
5. A first rate rehabilitation service in recognition that patients whose hospital stay was brief would need early support, education and risk factor management in order to improve outcome and two to avoid future readmissions.
6. A unit staffed by experienced well motivated doctors nurses and technicians driven by the desire to provide a high standard of care.
7. In principle, it was understood that any additional costs incurred by providing a higher standard of care could be offset by more efficient practices and a reduced hospital stay.

The service has been highly successful, and although it still does not run consistently to the standard that we aspire, it immediately resulted in the closure of a hospital ward and is estimated to save the trust/provider hundreds of thousands of pounds a year.

It would be interesting to calculate the cost savings achieved by adopting this model nationally and it would be difficult to envisage any saving leading to such an improvement in patient care.

In many ways the setting up of this service has involved similar changes to those we had to make when setting up the STEMI Service, in that it has involved similar changes to the working practices of doctors, nurses and technicians as well as the need to overcome the resistance of hospital and the NHS management who are traditionally resistant to any radical change. There is a need to have flexible working conditions that ensure staff are available when patients need treatment; a way of

working which is not enhanced by the current rigid and inflexible system of job planning. This is only achieved by having a common sense of purpose at all staffing levels.

The benefits to patients, the institution and the community of such a system are clear and the model should be considered as something that could be adopted more widely.

Conclusions

1. The provision of services for the management of cardiac chest pain cannot be separated from the management of other patients presenting with chest pain.
2. The service is most efficiently delivered in busy casualty departments close to the communities they serve. This applies to tertiary centres as well as to DGHs.
3. Access to specialist cardiac expertise at the consultant level is desirable 24 hours a day.
4. The immediate access to specialist cardiac investigations is essential.
5. NSTEACSs that are truly at high risk should be treated at heart attack centres and follow the NSTEMI protocol. These patients can rarely be identified in the ambulance and usually not until the initial treatment has failed.
6. The ability to perform early cardiac catheterisation is an essential part of treating acute cardiac ischemia as well as a non-cardiac chest pain.
7. Ambulance services should preferentially take patients suffering from chest pain without ST segment elevation to units that have cardiac catheterisation facilities, with consideration given to units that have specialist expertise available at first contact.
8. Seamless rehabilitation services that start on the day of admission and continue into the community following discharge.

Vascular surgery and cardiac surgery

I have not addressed the areas of vascular surgery and cardiac surgery and a number of points should be raised. In the interest of keeping this account concise I will only mention one:

The review concentrates on the more traditional important areas of vascular surgery. However it does not properly address the problems of lower limb ischaemia. This is a growing problem, particularly in diabetics and is huge cost burden for the NHS because of the cost of amputation and rehabilitation, and the need for extensive inpatient stays for patients who have chronic ischemia, ulceration and infection. There is a growing need for a model of care for these patients and it will almost certainly need to be centred proximal to the community it serves. There should be a proper cost evaluation of treating these patients as the reimbursement costs did not come anywhere near the true treatment costs.

Kevin Beatt

Appendix 6 – Response from London

Committee Services and Scrutiny
Bexley Civic Offices, Broadway
Bexleyheath, Kent, DA6 7LB
Tel: 020 8303 7777

www.bexley.gov.uk

Borough of Bexley

cardio-vascular@csl.nhs.uk.

Dear Sir or Madam,

London Cardiovascular Services: Proposed Model of Care – Consultation Response

Thank you for the opportunity to comment on proposals for the future model of care for cardiovascular services in London. We welcome any proposals to improve services provided to our residents.

Overall we consider the proposed model, if carefully implemented, has the potential to realise considerable improvements to clinical outcomes and patient care.

The consultation notes the need for cardiovascular treatment to respond to the growing demands of an aging population. Both Bexley and neighbouring Bromley boroughs have aging populations, with the 2001 Census showing that 16% of Bexley residents are aged 65 or over, which is higher than the Greater London average of 12%. When assessing need for cardiovascular services across London and in any subsequent mapping of services, it is therefore imperative the demography of our Borough is appropriately considered so that the needs of our aging residents can be adequately addressed.

We recognise that more specialised services may need to be delivered on fewer sites across London in order to improve patient care and clinical outcomes. We would be keen to learn more about how the proposed treatment networks would operate and how the different levels would interact across London to ensure a seamless patient journey from first contact to the end of treatment. We agree that intervention and care should reflect the clinical need of the individual patient, rather than being based on the services that might be operating at the time when the patient needs treatment.

We welcome the patient perspective that has influenced the consultation document. We feel that this perspective should continue be considered alongside clinical need as the proposals are further developed in order to achieve the best outcomes for patients.

We look forward to receiving further detailed proposals setting out how and where cardiovascular services may be delivered in future so that we can fully consider the impacts on Bexley residents.

Yours faithfully,

Councillor Ross Downing

Chairman of the Heath Overview and Scrutiny Committee

Appendix 7 – Response from London Borough of Croydon

Appendix b
Chief Executive's Department
Democratic & Legal Services
5th floor Taberner House
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Mr M Hindmarsh
Senior Project Officer –
Cardiovascular Surgery
Commissioning Support for London
Stephenson House,
75 Hampstead Road,
London,
NW1 2PL

29 October 2010

Dear Mark

Cardiovascular Surgery – Response to the Consultation

Thank you for your comprehensive & persuasive presentation on 11th October to members of Croydon's Health Scrutiny Committee of the proposed model for London cardiovascular services - also for pointing us towards the additional information on your web-site, which we have since reviewed. We are pleased to note that the proposals are supported by both clinicians & patients.

We fully support this proposed model of care, in terms of the anticipated improved outcomes it promises to achieve, bringing us into line with international good practice, as well as in terms of cost effectiveness.

Yours sincerely

Councillor Graham Bass
Chairman - Health, Social Care and Housing
Scrutiny Sub Committee

Appendix 8 – Response from London Borough of Havering

Havering
LONDON BOROUGH

Andrew Ireland
Group Director
Social Care and Learning

London Borough of Havering
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Andrew.Ireland@havering.gov.uk

Date: 8TH October 2010

Health For North East London
Aneurin Bevan House
81 Commercial Road
London
E1 1RD

To Whom It May Concern

New models of care proposed by Commissioning Support for London Response

I write in response to your letter dated the 27th August with regards to the proposed new models of cardiovascular and cancer care.

The London Borough of Havering welcomes any developments in the way care is delivered and received that will improve outcomes for patients and their families.

It is essential that outcomes for patients are the catalyst for any proposed models of care. The new model for cancer services must focus primarily on early diagnosis which will in turn impact on life expectancy, improved health and outcomes for patients and their families. Prevention and education are essential in significant improving cardiovascular services and their delivery whilst streamlining the existing cardiac services to improve patient pathways.

Havering welcomes the sharing of information and best practise between existing sites and organisations to improve the outcomes of patients. The consultation process requires a cross organisational approach to implement the configuration of services so as even distribution of services can be achieved, for example, the distance a patient needs to travel to receive care is not disproportionate to any other ensuring equality. With the proposed centralisation of complex vascular surgery and certain specialist cancer treatments the patients ability to travel will need to be addressed.

The Queens Hospital, Romford which is in the London Borough of Havering is one of the proposed sites for the new model of care for vascular surgery. There are a few social care elements that need clarification if this proposal is to work in an effective and timely manner :

- It is essential that there is a robust discharge protocol in place which is agreed and adhered to by all Local Authorities and PCT'

Once again the London Borough of Havering welcome any changes to the current care system that will improve the health and wellbeing of patients and their families. With partnership working and transparency the proposed models of care will be a move in the right direction for those in need of specialist vascular or cancer care.

Yours sincerely

Andrew Ireland

Appendix 9 – Response from London Borough of Merton

Thomas Pharaoh and Mark Hindmarsh
Commissioning Support for London
Stephenson House,
75 Hampstead Road,
London,
NW1 2PL

CC: Rt Hon Andrew Lansley CBE, MP

Scrutiny Team

London Borough of Merton

Merton Civic Centre

London Road

Morden SM4 5DX

Dear Tom and Mark

I write of behalf of the Healthier Communities and Older Peopl
to thank you very much for visiting on the 1st November 2010 a
succinct presentation.

There are one or two points I would like to feed back to you. I note at this stage the NHS has only provided funding for the proposed model of care for London cardiovascular and cancer services.

It is extremely disappointing that no provision has been made to produce models of care for preventative work e.g. cancer screening and programmes to provide healthy living for the residents of London.

It seems these models of care are rather "after the horse has bolted" and it would be much better to educate the residents e.g. talking bus stops and advertisements in buses and tubes and to inform residents as to the benefits of participating in screening projects. Not only would there be benefits to the residents e.g. lower death rate but a distinct benefit to the London taxpayer.

The panel also felt that money ought to be invested in the existing Information Technology systems to ensure that they are compatible amongst all users across the NHS.

I do hope that these suggestions can be taken on board

Finally, we would welcome sight of your report once you have completed your round of all participating boroughs

Yours sincerely

Councillor Gilli Lewis Lavender

Chair, Healthier Communities and Older People Overview And Scrutiny Panel.

Appendix 10 – Response from Londonwide Local Medical Council

Professor Nick Cheshire
Stephenson House
75 Hampstead Road
London
NW1 2PL

Londonwide LMCs
The professional voice of London general practice

1 October 2010

Dear Professor Cheshire

London Cardiovascular services: proposed model of care

Our team of Medical Directors here at Londonwide LMCs found it very helpful to meet Professor Toy and you to discuss London Cardiovascular services: proposed model of care. We can entirely understand the case for concentrating specialist services in a fewer number of hospitals. We note that no specific proposal has been made to identify the hospitals concerned. We can also confirm that when our individual Local Medical Committees, across London discussed the original Healthcare for London proposals, there was strong support for the concept for concentrating specialist services in fewer hospitals.

We have an initial meeting of the London GP Commissioning Council next week. This will bring together GPs from across London and we shall report on your very interesting work to our colleagues, after which I will feed in any additional comments.

Yours sincerely

Dr Tony Stanton

Joint Chief Executive

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Appendix 11 – Letter from The North West London Hospitals NHS Trust

The North West London Hospitals NHS
NHS Trust

Trust Headquarters
Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ

15 April 2010

Via Email
Caroline Taylor
SRO
Cardiovascular Services Project

Professor Matt Thompson
Clinical Lead
Cardiovascular Services Project

Dear Caroline and Prof Thompson

HfL Case for change for cardiovascular services

Thank you for sending me a copy of HfL's case for change which I have been reviewing with clinical colleagues. I appreciate that the case is not strictly out to consultation but I wanted to raise some important points that I hope will be considered as part of the development of the subsequent model of care.

Vascular services
While I appreciate the clinical arguments for providing surgical care in a high volume hospital by a specialist team we have some concerns how major acute hospitals (MAHs) will able to support high levels of acute demand with potentially no on site vascular support. The case for change rightly emphasises the need for clear pathways for i) patients from hyper acute stroke units (HASUs) requiring carotid endarterectomy surgery and ii) trauma patients requiring specialist emergency vascular services. It makes no specific reference, however on the expectation that MAHs will provide a comprehensive emergency surgery service to catchments of potentially 1m people. We think that the case for change needs to make reference to the specific role of major acute hospitals and their inevitably close relationship with the arterial surgery centres. Similarly we think it is important that any subsequent model of care clearly explains how services could be configured to ensure that the

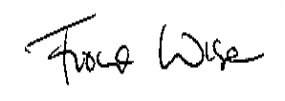
large number of patients presenting at MAHs with vascular needs receive optimal care.

Cardiology
The need for greater clarity about the role of MAHs applies also to the cardiology case for change. MAHs could foreseeably be supporting 35,000 emergency medical admissions pa and will be required to run busy cardiac services. We fully endorse the key message that patients suffering from an NSTEACS event should have an angiogram within 24 hours and anticipate that all MAHs will need to be able to deliver this level of service. We also anticipate that elective PCI should be undertaken at MAHs able to support a minimum 400 elective procedures PA.

We believe that as long as units can meet this critical mass, then patients can benefit from a local interventional service. We would not like to see a return to the past when patients often waited weeks in hospital for PCI at the tertiary centres.

We hope that by clarifying the role of the major acute hospital in the delivery of high quality cardio-vascular services will address the concerns raised.

Yours sincerely



Fiona Wise
Chief Executive
North West London Hospitals NHS Trust

Appendix 12 – Project response to the letter from The North West London Hospitals NHS Trust

Commissioning Support for London

Healthcare for London cardiovascular project
Commissioning Support for London
18th Floor
Portland House
Bressenden Place
Victoria
London
SW1E 5RS

Wednesday 5th May 2010

Fiona Wise
Chief Executive
North West London Hospitals NHS Trust
Northwick Park Hospital
Watford Road
Harrow
HA1 3UJ

Dear Fiona

HfL Case for change for cardiovascular services

Many thanks for your letter dated the 15th April 2010 responding to the cardiovascular case for change document. It is worth clarifying the project scope and remit of the cardiovascular review first before going on to address the detail of the issues you raised around vascular surgery and management of non-ST elevation acute coronary syndrome (NSTEACS) patients.

The review focused on improving outcomes for patients undergoing cardiovascular surgery and interventional procedures. The purpose of the review was not to attempt to define the services that should go into a major acute hospital (MAH) site. To that extent, the review has made a series of recommendations that relate to how a quality service should look, what the essential clinically dependent cardiovascular services are and what standards an excellent cardiovascular service should be meeting. It does not address the issue of where these services should be provided.

It is our intention that the documentation will help inform discussions between providers and commissioners in each of the sectors so that all patients have access to an excellent cardiovascular service. As you point out however, there are obvious implications for MAH sites which will need to be worked through within each of the sectors.

In relation to the point you made around the provision of vascular surgery at MAH sites, your concern is that with the centralisation of vascular

surgery onto fewer sites, there will not be enough vascular surgery provision to support emergency surgery at all of the MAH sites. When the model of care is published following the election, it will recommend that there should be a maximum of five sites in London that provide arterial vascular surgery. The project clinical groups felt that this number of sites would be the most likely to deliver the improvements in patient outcomes we want to see. Sectors and providers will need to come together locally, supported by CSL, to work through how this can be achieved and what this means for individual units.

The project team at CSL will continue to work with sectors to ensure that the Healthcare for London pathways and sector strategies can be aligned and are delivered.

In relation to services for high risk non NSTEACS patients, we have again not described the type of hospital that this should take place in. However we will clearly outline the markers that will deliver patients an excellent service. It is likely that in order to deliver the changes in service described, that hospitals will need to work together, and that access to some advanced and complex services will form a key part of that.

We trust this information is useful and look forward to working with you and sector colleagues as we progress with the implementation of the review.

Yours sincerely

Caroline Taylor
Senior responsible officer, Healthcare for London cardiovascular project & chief executive, NHS Croydon

Prof Matt Thompson
Clinical director, Healthcare for London cardiovascular project & consultant vascular surgeon, St Georges Healthcare NHS Trust

Appendix 13 – Comments on mitral valve surgery from University College London Hospital NHS Foundation Trust

Our belief is that mitral valve repair surgery for degenerative valve disease should be in the armamentarium of 2-3 specific surgeons in each surgical group whose performance should be monitored. However exclusive designation of this technique in all circumstances is to the overall detriment of general cardiac surgery delivery and the designation should not be exclusive.

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Proposed service specification for a local vascular surgery unit

GPs should continue to refer their patients to the hospital of choice in the usual way. Once referred, patients would be seen on an outpatient basis in the usual way for any venous surgery. Local units would be responsible for triaging and transferring elective arterial patients to a central unit, where appropriate.

The local unit should provide the following services:

1. Procedures

No arterial vascular procedures should be commissioned from a local unit. Local units should be commissioned for the following procedures.

- Varicose vein surgery
- Any other day-case venous vascular surgery
- Surgery on the lymphatic system
- Limb angioplasty (if the unit also have a coronary angioplasty service)
- Amputations

Local units should continue to deliver a full range of vascular diagnostics and outpatient services.

2. Emergency service

In conjunction with the centralised unit and London ambulance service, local units should develop protocols so that any patients presenting who require emergency arterial surgery can be safely transferred to the central unit.

3. Governance and network arrangements

Local vascular units should work as part of a regional vascular network, with the central unit acting as the hub for the network. Vascular surgeons based at the local units should continue to provide an outpatient service and the full range of vascular diagnostics. They should have their own regular operating list at the central unit, onto which they can refer patients from the local unit. For the majority of patients this means that any surgical work-up will be undertaken locally and they will travel to the central unit for their complex surgery.

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Agenda Item 6

North Central London
NHS
Barnet - Camden - Enfield
Haringey - Islington

THE NHS IN NORTH CENTRAL LONDON	**BOROUGHS:** All **WARDS:** ALL

REPORT TITLE: Quality, Innovation, Productivity and Prevention – Commissioning Plans for 2011/12

REPORT OF:
Nick Losseff, Consultant Neurologist and Clinical Director, NHS North central London
Senior Responsible Officer QIPP, NHS North Central London.

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 21st January 2011**

SUMMARY OF REPORT:

This report provides members with an overview of the commissioning plans that have been developed across the NHS in North Central London. At the November meeting members discussed the case for change described in the document "Now and into the Future" This brought together the challenges faced by the health system and described the evidence under-pinning why we must change in order to improve clinical quality, productivity and services for patients.

Since then there has been a focus on developing plans and initiatives for the coming operating period (2011/12) and into the medium term. This has been done through the Department of Health's Quality, Innovation, Productivity and Prevention (QIPP) programme.

It provides plans for initiatives under eight broad headings:

- Medicines Management
- Primary Care
- Cancer Services
- Decommissioning and Thresholds
- Mental Health
- Maternity Services
- Care Closer to Home
- Unscheduled Care

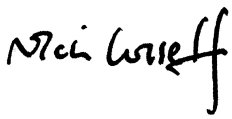
Some specific issues and initiatives are picked up in other items on this agenda.

At the time of writing this paper, the first draft of the North Central London QIPP plan, is due to be submitted to NHS London in the week commencing 17 January. We will provide a copy of the draft plan to Committee Member as soon as it is available, and prior to the meeting on 21 January. This document will contain whole QIPP plan including associated plans for finance, transition, workforce and contracting. A final plan has to be submitted to NHS London on 28 February.

CONTACT OFFICER:
Sylvia Kennedy
Director of Clinical Strategy, NHS North Central London
Telephone 0203 317 2794 Email sylvia.kennedy@islingtonpct.nhs.uk

RECOMMENDATIONS:
Members are asked to consider the content of this summary report and, once the draft QIPP plan is available, identify those issues which they may wish to review or scrutinise in subsequent meetings.

SIGNED:



Dr Nick Losseff
Clinical Director, NHS North Central London
DATE: 14 January 2011

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Agenda Item 7

North Central London NHS
Barnet - Camden - Enfield Haringey - Islington

THE NHS IN NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL

REPORT TITLE: **AN UPDATE ON THE MENTAL HEALTH WORK PROGRAMME**

REPORT OF:
Cameron Ward
Chief Executive, NHS Barnet &
Senior Responsible Officer for Mental Health at NHS North Central London.

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 21st January 2011**

SUMMARY OF REPORT:

Members of the Committee received a general update of the work taking place in the mental health work programme across all 5 boroughs. In addition to the work that is taking place at a sector level, a separate Barnet Enfield and Haringey Mental Health Transformation Programme has been established, which is a joint arrangement between Barnet, Enfield and Haringey Mental Health Trust and the three local commissioners (NHS Barnet, NHS Enfield and NHS Haringey). The focus of this report is on this transformation programme which is constructed of 9 individual projects.

Camden & Islington NHS Foundation Trust are undertaking a savings programme in conjunction with their commissioners NHS Camden and NHS Islington. A formal consultation under s.244 of the NHS Act 2006 into a proposal to both close inpatient beds and reduce the number of inpatient sites began on January 4th and will be scrutinised within the two boroughs concerned. A verbal update on this work can be provided to members if required. The consultation document is appended to this report for information.

CONTACT OFFICER:
Susan Beecham
Programme Manager (mental health)
NHS North Central London
susan.beecham@camdenpct.nhs.uk

RECOMMENDATIONS:
The Committee is asked to note the content of this report and to raise any concerns or queries and to give their views on the work that has been taking place to improve local mental health services.

Attached is Appendix One, An update on the proposed statutory consultation in Camden and Islington, as part of the Mental Health Commissioning and Transformation Programme
.

SIGNED:

Susan Beecham
Programme Manager (mental health)
NHS North Central London
susan.beecham@camdenpct.nhs.uk

DATE: 14 January 2011

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Update on Mental Health Commissioning and Transformation Programme

1. Introduction

The overall direction of travel of local mental health services is reasonably clear. It reflects the national strategy, the local commissioner's three-year Mental Health Strategy and Barnet, Enfield and Haringey Mental health Trust's "Changing for good" programme. Although it should be noted that this strategy has not been formally signed off within Barnet

All of these documents set out the same broad strategic direction a development of mental health services across the three boroughs:

1. Services based on the recovery model
2. Greater development of community services and reducing reliance on in-patent care
3. Providing the most clinically and cost effective, value for money services
4. Working in partnership to develop and implement an ongoing change programme

In order to deliver these strategies NHS Barnet, NHS Enfield, NHS Haringey and Barnet, Enfield and Haringey Mental Health Trust have agreed to work together to deliver a mental health transformation programme that delivers the strategic direction.

From discussions with a wide range of stakeholders, including service users and carers, Overview and Scrutiny Committees and local authorities there is general support for the broad direction of travel, with most stakeholders recognising the pressures for change and the benefits for service users. However, there are concerns from a number of stakeholders to understand the practical milestones and how the strategy will be delivered

This document will demonstrate how the individual projects that make up the mental health transformation programme support the agreed strategic direction of mental health services across the three boroughs.

2. Summary of Strategies

a) National Context

The Department of Health launched New Horizons: towards a shared vision for mental health" a formal consultation on the development of mental health services in England over the next few years.

The key themes it raises are:

- Prevention and public mental health, promoting mental well-being as well as treating mental health problems
- Reducing stigma and promoting social inclusion
- Early intervention to improve long term outcomes
- Personalisation of care, leading to individuals' recovery
- Multi-agency commissioning / collaboration
- Innovation, greater use of research and new technologies
- Value for money, delivering greater cost effectiveness

- Strengthening transition from child and adolescent services to adult services.

These themes have then been reflected in the local strategies

b) Current service provision

Although there are many examples of excellence in the services as currently provided. We know that there are areas that we could improve. In the past, services for people facing mental health problems have been focused on a narrow area – providing specialist help to people with the greatest needs often within a very institutional model. Rather than helping people to integrate into society we have been all too ready to take them out of it, focusing on large inpatient hospitals.

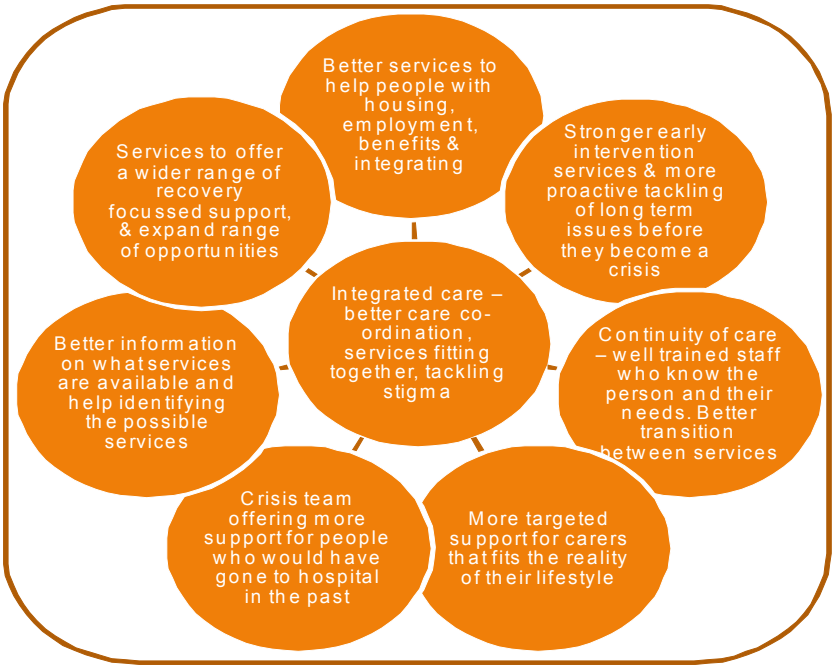
These have provided a secure and safe environment, but have limited people's overall recovery, particularly their integration into their local communities and developing their independence. Services have also been very separate, arranged in different ways by different providers, often with poor communication between them – so people have experienced care as being disjointed, and not centred on their personal needs.

We have come together to develop this strategy because we are determined that local people should have services that are driven by individual need, help them to live their lives to the full and enable them to maximise their potential. This means we have to focus not only on services for people who are already facing mental health problems, but also on preventing mental ill-health and promoting wellbeing.

Therefore we need to develop and structure our community based mental health services to best support those with mental illness to recover and to promote mental wellbeing. Our services are still too focused on inpatient healthcare at the moment, and are not fully comprehensive or sufficiently "joined up" to meet the full range of needs of individual patients.

This is supported by what we have heard from service users and carers through our various engagement mechanisms, including the Mental Health Trust's "Changing for Good" programme

Some of the key messages that we have drawn from what service users, carers and local people have told us about the changes they would like to see are summarised below.



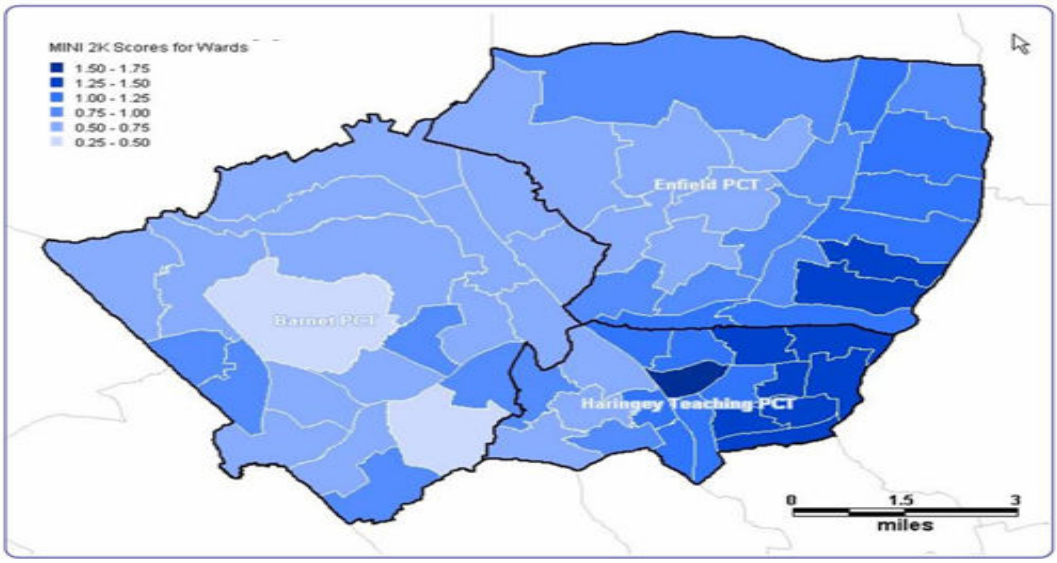
c) Local Health need

Assessing mental health need is very challenging. We know that many people with mental health problems do not access mental health services. This is for many reasons including the fear of stigmatisation.

We do know that need increases in areas with a high degree of social deprivation, and that prevalence of mental illness is higher than average for people who leave school early, are economically inactive, have disabilities, are unemployed, have more than one physical illness, and who are lone parents.

One way commonly used to assess mental health need is the MINI 2000 index which identifies the likely prevalence of mental health problems based on a number of socio economic indicators.

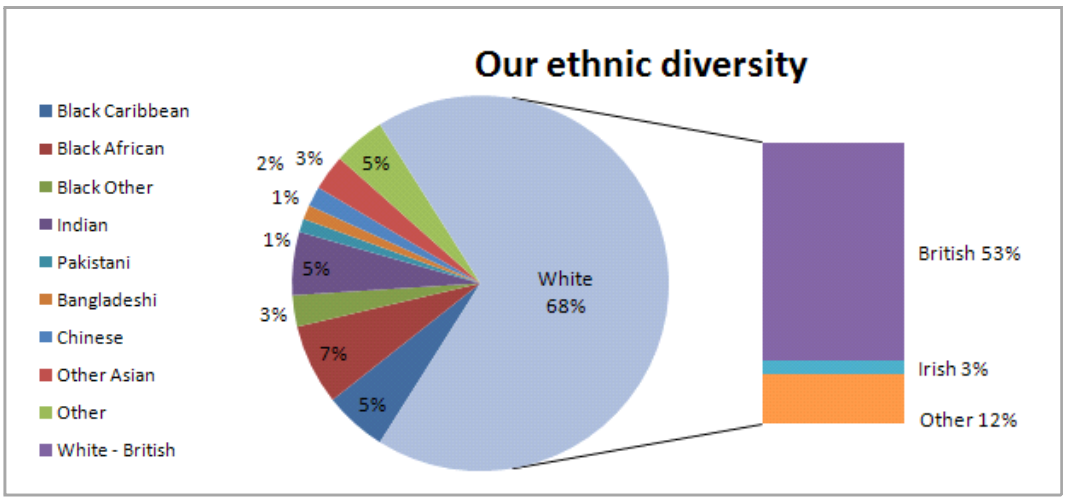
The map below shows how need for mental health services varies across Barnet, Enfield and Haringey. The darker the colour the higher the likely need.



Most of the areas with the greatest level of need are in the East of Haringey and Enfield, particularly within Haringey, which has the highest proportion of localities with above average needs.

We also know that age and ethnicity also affect the need for mental health services. Not only is the population of our local boroughs expected to grow considerably, albeit it a different rates across the three boroughs, but the age profile and ethnic mix is also going to change over the next five years.

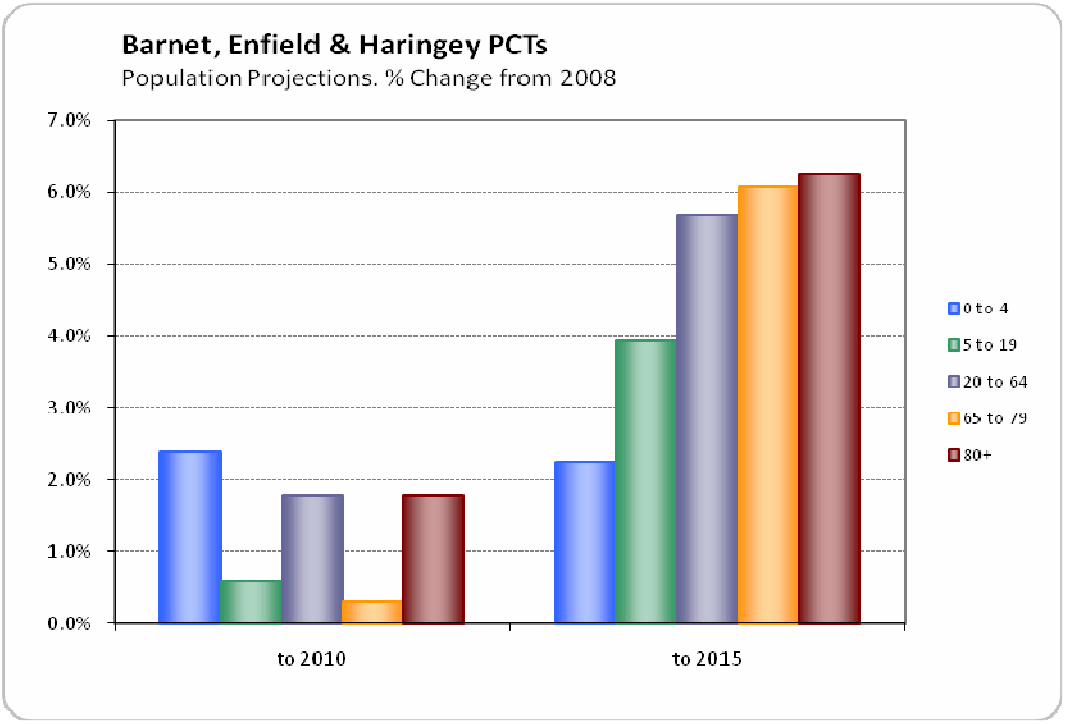
Across the three boroughs we have one of the most diverse populations in the UK as illustrated below. We estimate there are at least 25 languages regularly used within our three boroughs.



In considering our diversity it is also important to note that we have a relatively high proportion of “other white residents”. In Barnet this group represents 11% of the population, 13% in Enfield, and 16% in Haringey. These are mostly Turkish, Cypriots and Eastern Europeans.

The populations are changing too. Not only will the ethnic mix change (with a gradual reduction in the proportion of the population who are white in Barnet and Enfield (between 3 and 4%) with a very slight decrease in Haringey), but also the age balance within the populations. Overall, the three boroughs will see an increase in population size – from around 840,000 in 2008 to around 884,000 in 2015. However, the vast majority of this growth will be in Barnet, with a small increase in Haringey, and the population in Enfield being almost static.

The chart below shows how the population as a whole is expected to change in terms of age balance between 2008 and 2015.



This means that the needs of the different populations will be very different across the three boroughs, and between different areas in the same borough, because there are wide variations in levels of deprivation.

In headline terms the key differences in need between the boroughs, driven by their different populations, are:

- Haringey has the greatest level of need within adults of a working age – this reflects its relatively high level of deprivation. It also has a higher proportion of people from the black community, and this group is a relatively high user of mental health services.

- Barnet has the largest Asian population – and as a group this community tend to make less use of mental health services. However, the age of its population (and the population growth in older age people in Barnet) means that services will need to be focussed more on older people, and particularly on the problems of dementia.

In conclusion, although we will be seeking to standardised access to and ensure consistency of the quality of services across the three boroughs we will also ensure that the very different needs of the boroughs are effectively met.

d) Financial constraints

Since the Comprehensive Spending Review we know that the broad financial implications are for circa. £20billion cost reductions in NHS spend over next four years.

The NHS, local authorities and other parts of the public sector are strongly advised to plan on the basis of very significant financial challenges over the coming years. A recent authoritative joint report from the Kings Fund and the Institute of Fiscal Studies ('How cold will it be? Prospects for NHS funding: 2011-17', July 2009) emphasise that, after significant real growth in NHS funding over recent years, future NHS funding looks tight. The report considers a number of potential scenarios for NHS funding over the next few years and suggests that the NHS could see very little real terms growth or even real terms funding reductions (compared to average annual growth of 7% over recent years).

Another recent report from the NHS Confederation ('Dealing with the Downturn', June 2009) suggests the NHS in England is facing real terms funding reductions of 2.5 – 3 % per year after 20011/12. This would equate to a very severe contraction in NHS finance of £15 billion in real terms over the five years from 2011. The NHS Confederation report predicts that given likely continued demographic growth and increasing demand for health services (particularly from older people and for mental health services in a recession), it is very likely that the whole of the NHS will face unprecedented financial challenges over the coming years.

Both of the above reports strongly advise that the NHS should be planning now for this financial position, in order to achieve continued quality improvements with efficiency increases and cost reductions that do not damage patient care or compromise long term health improvement.

In conclusion, the financial environment the NHS finds itself in is significantly challenging. The need to dive up quality and improve value for money is paramount. We recognize that by working together we will deliver more than we can individually and this programme is how we intend to work together on both strategic direction and the need to improve value for money.

e) Changes to services

In order to deliver the new ways of providing mental health services, meet the increasing needs of the population, whilst improving the cost effectiveness and value for money both the commissioners and provider organization identified similar proposed changes to how services could potentially be changed, as these extracts from both the provider and commissioner strategies demonstrate:

The key service changes that are identified within the Commissioner Mental health strategy are as follows:

- Improved community based crisis services – expert support to prevent people needing hospital treatment and crisis houses.

- Increased access to psychological therapies – building on existing investment to provide a range of treatments in mainstream settings.

- Better signposting and care navigation services – helping people get to the services they need.

- More services that support inclusion – more choice than traditional day services.

- Reduced length of stay in hospitals – moving people on when they need to.

- Preventing unnecessary admissions to hospital settings – ensuring safe and secure care is available outside of hospital.

- Minimising the use of hospital beds for patients who need long term care – developing alternative community provision.

The key service changes that are identified within the Provider Mental Health Strategy "Changing for good" are as follows:

- Creating fewer, more centralised, specialist units where clinically appropriate e.g. psychiatric intensive care unit (PICU), serving the whole of Barnet, Enfield and Haringey.

- Continued reductions in lengths of stay on adult inpatient wards (through better care co-ordination) and redeployment of resources released from inpatient services to develop adult crises and home treatment teams and other services, such as practical support teams and dementia support teams based in the community.

- Developing new alternatives to inpatient admission, such as locality based Crises Houses.

- Developing community based mental health services for older people and reducing the need for inappropriate inpatient admission of older people

- Building capacity in community mental health teams to support and direct the Recovery pathway back to social inclusion.

- Improving the care pathway for service users through the reorganisation of crises and home treatment and inpatient services to deliver a functional model of care.

- Reviewing the provision of traditional rehabilitation services and developing specialist, community based, active rehabilitation services and the creation of more centralised, more specialist, inpatient rehabilitation facilities, likely to serve the whole of Barnet, Enfield and Haringey.

- Looking for opportunities to develop new services not currently provided, e.g. a new, non Forensic, low secure unit, serving the whole of Barnet, Enfield and Haringey.

As can be seen from the above extracts from the strategies there is a high degree of consistency between both the local commissioners and providers in terms of the service changes that they would expect to see in the coming years. These changes can be consolidated and summarised in one set of consistent service changes as follows:

- More specialized units serving all three boroughs
- Reducing the need for in patient beds
- Developing Community health services
- Improve rehabilitation services
- Re-organising Crisis service
- Improved access to Psychology services
- Support inclusion and recovery
- Repatriation of out of area work to more local services

3. The Mental Health Programme

A whole system approach to these changes in service provision is planned, with all three PCTs and the Mental Health Trust working together, alongside our local authorities and other partners, service users and carers.

The Programme consists of nine projects which can be grouped into two broad areas:

1. **Developing community services**
   a. Community Mental Health Teams (CMHTs)
   b. Developing Recovery / Crisis House capacity
   c. Children & Adolescent Mental Health Service (Tier 4)
   d. Dementia Care Pathway
   e. Continuing Healthcare

2. **Specialist services**
   a. North London Forensic Service (NLFS)
   b. Brain Injury Rehabilitation Unit (BIRU)
   c. Substance Misuse and Alcohol patients
   d. CAMHS and Eating Disorder Services (EDS)

However, it is important to differentiate between the service elements of the projects and the impact these projects might have on the estate. It is not intended to formally consult on the service changes as individually they do not represent a significant change in service. As these are all stand alone schemes together they do not amount to service reconfiguration or significant service changes. The resulting impact on the estate might have significant issues for the estate and if that is the case then full consultation will be undertaken.

3.1 Developing community services

a Community Mental Health Teams

Project description

In order to ensure that the community services are able to meet current and future demands this project reviews how they currently operate, move from generic teams to teams based around functions e.g. psychosis and ensure that the work they are undertaking could not be more appropriately done elsewhere. This work brings services in line with the new service line structure and enables services to be delivered in line with the future requirements of mental health payment by results.

Impact on service provision

The impact on service of provision is that patients should benefit from a more integrated service, which will deliver more consistent care. Although there will be a reduction in the number of community mental health teams, there will be no reduction in overall staffing number or service provision as a result of this project. There may be different people doing different things. There will be no adverse effect on any of the other projects or any other service provision

Consultation

Whilst there will be engagement with key stakeholders, it is not intended that there will be any formal consultation as all the activity that is currently provided will still

be provided albeit in a different way. BEHMHT has already completed a staff consultation. It is intended that this project will be completed by March 2012

b Child and adolescent specialist services (Tier4)

Project description

The overall aim of this project is to review the existing care pathway and develop a new care pathway for children and young people admitted to in patient psychiatric units or those at risk of an in patient admission. In particular it will consider how community services can be improved to improve the quality of care and reduce the requirements for inpatient beds.

Impact on service provision

The services provided at Northgate and New beginning adolescent inpatient units will be brought together to provide a service based on one model and similar to that of a few years ago as the changes made have not provided the anticipated improvements. It is anticipated that there will be a reduction in the number of beds, which will fund an integrated community service and release savings. This is a stand alone project and has no impact on any other project.

Consultation

There will be due engagement with staff and whilst there will be engagement with key stakeholders, it is not intended that there will be a formal public consultation. This is because this is not a significant change in service provision. Northgate and New Beginnings are on the same site and are currently situated adjacent to each other at Edgware Community Hospital. Therefore there would be no loss of service from that site. The project will be completed by March 2012

c Recovery Centres

Project description

The overall aim of this project is to provide a Recovery Centre in each of the three boroughs. These houses will provide a better therapeutic environment for supporting individuals who require more than just community services, but who would not benefit from an inpatient bed.

Impact on service provision

It is intended that all assessed patients will be better supported through the Home Treatment Teams in this non-clinical environment, rather than an in patient ward. This also means that there will be increased clinician contact time less disruption to the lives of those patients thought suitable to benefit from this treatment approach. There will be no reduction of beds overall, but there will be a change in who provides theses beds and the therapeutic input into them will be increased. This is a stand alone project and has no impact on any other project.

Consultation

There will be due engagement with staff and whilst there will be engagement with key stakeholders, it is not intended that there will be a formal public consultation. This is because it is not a significant change in service provision. Although there will be a change in sites, in the first instance there will be an increase in beds therefore it is not proposed to formally consult on this change. However it is envisaged that the variation on the model of care proposed for offering inpatient treatment will lead towards less hospital beds being required for the future. Plans

for the reduction of inpatient beds that will no longer be required will be consulted upon approximately one year after implementation to allow enough time to review the impact that the changes have made.

The Recovery Centres project is expected to be completed by March 2011

d Dementia Care

Project description

We know that demand for dementia services is going to grow in the future as a result of an increasingly elderly population. This project is about looking at the whole of the care pathway from assessment to end of life care to ensure we have appropriate services in place.

Impact on service provision

This work has not been fully scoped yet; therefore it is too early to identify what the impact on service provision is likely to be.

Consultation

There will be engagement with key stakeholders and a formal public consultation will be undertaken if required. The project will be completed by March 2012

e Continuing Health Care

Project description

Both providers and commissioners have agreed that continuing care is not part of the core services of BEHMHT. Therefore these types of patients will no longer be admitted in BEHMHT in-patient wards. Those that are already in existing beds will be reviewed. If it is agreed that these individual's needs are best met in a non hospital, nursing home type setting rather than a ward environment, then they will be transferred to more appropriate accommodation. It is planned that all patients who it is appropriate to transfer to a different environment will have been transferred by Spring 2011.

Impact on service provision

There will be no reduction in the number of beds funded by the NHS overall for this client group although it is anticipated that there will be less NHS provided beds. More beds will be provided in the independent sector. These changes will not take place without involvement from patients and their families. The project will also review the requirement to invest in community services to support more people in the community. Although this will not be from the CMHT's therefore this is another stand alone project. .*The proposal is that Elysian House would then become one of the recovery houses (see recovery houses above)*

Consultation

As this is about the best care for individuals, it is not intended to consult formally on these service changes; however there will be full engagement with patients, carers and staff. Any subsequent estates issues will be formally consulted upon.

3.2 Specialist services

a Forensics

Project description

At the present time there are a number of expensive placements in institutions that are not based locally. The aim of the project is to repatriate as many of these out of area placements more locally and under the care of BEHMHT.

This project will review each out of area placement individually and ensure that the individual concerned is placed in the most suitable environment to support recovery and inclusion as appropriate.

This project will also review the current care pathway as individuals go through it. And identify new improved care pathways.

Impact on service provision

It is not intended to reduce the current number of beds, but rather use them more effectively, which may result in the designation of some of the beds changing from medium to low secure

Consultation

It is not intended to undertake a formal consultation on this project. It is intended to have everyone who is suitable to be repatriated by December 2010 and have a new pathway in place by April 2011

b Brain Injury Recovery Unit (BIRU)

Project description

It has been agreed by both providers and commissioner that the BIRU is not part of the core services of BEHMHT. This is highly specialised work and is commissioned across the whole of London by the specialised services commissioning group. The service is not currently fully utilised and treats very few residents of the three boroughs being a pan London based service.

Impact on service provision

At the present time the service is not working at full capacity. There are no Enfield or Haringey patients and only two Barnet patients in the unit. This services needs to be considered by the London Specialist Commissioning Group; however the project has no impact on any other projects

Consultation

If a consultation is required, the London Specialist Commissioning Group will be required to lead the consultation process

c Substance Misuse

Project description

Last year NHS Enfield tendered their substance misuse services as provided by BEHMHT. This project will manage the process of NHS Barnet and NHS Haringey tendering their services. NHS Barnet will be completed by March 2011 and Haringey will complete March 2012

In addition the project will also look at whether or not investment in alcohol services can reduce the number of admissions into acute hospital settings. This work will be completed by June 2012.

Impact on service provision
As this project is about improving the price paid for services it is not anticipated that there will be major service changes which arise as a result of this project. However if there is an overall reduction in levels of central funding this position will have to be reviewed and any changes will be agreed by the multi agency DAT group. This is a stand alone project and has no impact on any other project

Consultation
It is not intended to undertake formal consultation for this project as there are no major service changes and the anticipated reduction in funding will be managed through the normal annual contracting process like any other contract.

d Child and Adolescent Eating Disorders Service

Project description
The overall aim of this project is to review the existing care pathway and develop a new care pathway for children and young people with eating disorders. In particular it will review existing outpatient services which are provided by the Royal Free Hospital, as well as looking to develop viable alternatives to expensive out of area placements.

Impact on service provision
The main impact of this project will be to invest in an outreach service integrated with the current out patient service to provide more services locally which will reduce the need for expensive out of borough placements. This is a stand alone project and has no impact on any other project.

Consultation
Whilst there will be engagement with key stakeholders, it is not intended that there will be any formal consultation as this does not represent a significant service change. The project will be completed by March 2012.

How each of these projects support the planned services changes as outlined in the table below:

Planned Service Change	1a	1b	1c	1d	1e	2a	2b	2c	2d
Specialised units	√		√			√	√		√
Developing Community Services	√	√	√	√	√	√		√	√
Rehabilitation Services	√	√				√	√	√	
Crisis Services	√	√						√	
Psychological Services	√			√					
Inclusion and Recovery	√	√	√	√	√	√		√	√
Repatriation	√			√			√	√	

4. Conclusion

The NHS in general and mental health services in particular is facing significant challenges in the forthcoming years. There is a great synergy between all the existing strategies of how these challenges should be met. They are all consistent in describing their direction of travel and have identified the same planned changes in service provision. The nine projects that make up the mental health programme are critical in delivering the service changes required to implement these strategies.

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North Central London NHS
Barnet - Camden - Enfield
Haringey - Islington

THE NHS IN NORTH CENTRAL LONDON	**BOROUGHS:** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL

REPORT TITLE: Low Priority Treatments extended policy

REPORT OF:
Sylvia Kennedy,
QIPP Programme Director/Senior Responsible Owner
NHS North Central London

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE:** 21st January 2011

SUMMARY OF REPORT:

The existing *Low Priority Treatments policy* sets out the North Central London PCTs' policy on not commissioning 'low priority' treatments' (LPTs) routinely; and requests for funding such treatments will be considered individually.

The policy has been in place since 1 September 2010 for all new referrals. Where there have been significant changes locally, these have been discussed with the relevant borough's Health Overview & Scrutiny Committee.

The policy has now been updated to include additional procedures recommended by Commissioning Support for London (CSL), and to incorporate changes made in light of secondary care clinician feedback.

This *Low Priority Treatments extended policy,* which includes the additional procedures, (pages XI – XX) forms the basis of this report.

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RECOMMENDATIONS: The Committee is asked to comment on the *Low Priorities Treatment extended policy*, attached in Appendix One.

SIGNED:

Sylvia Kennedy

Sylvia Kennedy, QIPP Programme Director & Senior Responsible Owner (SRO)
DATE: 14 January 2011

Low Priority Treatments extended policy

This policy includes additional procedures that have been added to the existing proscribed *Low Priority Treatments policy*. The additional procedures are:

- Knee washout for osteoarthritis
- Apicectomy
- Unilateral bone anchored hearing aids for unilateral deafness (implanted one side) &
  Bilateral bone anchored hearing aids (implanted both sides)
- Autologous Cartilage Implantation (ACI)
- Injections for non-specific back pain
- Spinal Fusion for chronic low back pain
- Spinal cord stimulation
- Surgical discectomy (standard or micro), percutaneous discectomy, coblation therapy and laser discectomy for lumbar disc herniation
- Surgery for snoring
- laser-assisted uvulopalatoplasty (LAUP)
- uvulopalatopharyngoplasty (up3)
- radiofrequency ablation of soft palate (RFA)
- Caesarean section for non clinical reasons

NCL activity data for 2010/11 has been obtained for additional procedures above and shows that this relates to approximately 2,997 people across the sector.

What will happen to the patients currently receiving the affected services?
Low Priority Treatments will not be funded routinely but only on consideration of individual patient circumstances, i.e. on a 'prior approval' basis.

This means that, for individual patients, it will restrict access to previously available treatments.

An Equality and Diversity Impact Assessment has been carried out and is attached as Appendix 3. This assessment shows that implementation of the extended policy will have no differential negative impact.

Who will benefit from our proposal?
Extending the list of Low Priority Treatments will ensure that the limited budget will be utilised to ensure the maximum advantage of the maximum number of people.

Will this save money?
The *Low Priority treatments policy extension* sits within the QIPP Demand management workstream (which includes decommissioning and thresholds).

These treatments cost £3,169,350 and, assuming activity reduction of 80%, implementation of the extended policy is expected to deliver financial benefits of £2,535,480 from 2011/12.

Public Consultation and Engagement
Discussions have taken place with GPs and secondary care providers and the extended policy reflects their comments and recommendations. The additional procedures included in the extended policy, as a result of these discussions, are listed on pages XI – XX.

This policy has been discussed with NCL LINks on 14th December 2010.

NHS Islington is intending to hold a 3-month public consultation on Homeopathy because of a previous promise to consult. (Homeopathy is part of Complimentary medicine of all types, which is included in the existing *Low Priority Treatments policy*) NHS Haringey will also go to public consultation, synchronising information and process with NHS Islington. Barnet has stopped the routine funding of Homeopathy and complementary medicines. Enfield has had a policy of exclusion from referral for the last 2 years. Camden is not intending to go to public consultation but will discuss with local LINks and Overview and Scrutiny Committee.

Your views
We would like your views on the *Low Priority Treatments extended policy*

If residents of your boroughs have any questions about this *Low Priority Treatments extended policy* or would like to receive further information or information in another format, please contact:

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North Central London
NHS
Barnet - Camden - Enfield
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Policy for 'low priority' treatments

1 Introduction

This paper sets out the North Central London PCTs' policy on not commissioning 'low priority' treatments routinely; requests for funding such treatments should be considered individually. This policy has been drawn up in the context of the principles framework used by three of the North Central London PCTs and the new NHS Constitution.

1.1 Context

1.1.1 Why might some treatments be considered to be of 'low priority'?

We cannot support the commissioning of services and treatments that are known to be clinically ineffective,[i] nor those that are not cost effective. We also consider that treatments that may be clinically and cost effective should not be commissioned if they are unaffordable because of in-year financial pressures, or if their opportunity costs are high and funding them could thereby deny clinically and cost-effective treatments of more significant conditions for others. 'Low priority' treatments are thus those where the evidence of clinical and/or cost effectiveness is limited (or they are only clinically effective in a specific group of people or in certain clinical circumstances, when they might be funded), and/or where not funding such treatment is unlikely to have a significantly adverse effect on the patient's physical or mental health or ability to undertake everyday living activities with reasonable independence.[ii]

If resources are used for one person then those same resources are not available for someone else. So, if we give resources to one person that are disproportionate to their need or ability to benefit then we deny those resources to others who might benefit more and this would be inequitable.

In addition, if a treatment is funded for one person then that treatment should be funded for all people in similar circumstances; to do otherwise would be inequitable. Thus, if funding a large number of treatments for conditions that do not have a major impact on people's lives would reduce the amount of money available to fund clinically and cost effective treatments for conditions that have a significant effect on people's lives, then we could not use our resources to the greatest benefit of the greatest number. This principle was probably first articulated in court in an NHS context in the 'Child B' case[iii] (this is referred to in more detail in Appendix 1: the Framework of Principles).

2 What treatments might be considered to be 'low priority'?

The list of 'low priority' treatments in Appendix 2 is not exhaustive, rather, it is indicative of the types of treatments that we consider are likely to be of lower priority for funding than others and that thus we will not routinely fund. We may formally add to this list and we reserve the right to define other treatments and clinical interventions as being of 'low priority' in the light of further reviews and/or individual patient treatment funding requests and/or proposals for service developments.

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i Clinical effectiveness is the extent to which specific clinical interventions, when deployed in the field for a particular patient or population, do what they are intended to do – that is, maintain or improve health, and secure the greatest possible health gain from available resources [NHS Executive. *Promoting Clinical Effectiveness: a framework for action throughout the NHS*. Department of Health, 1996]

ii In contrast, a 'high priority' treatment might be one that was literally life saving or one that might reasonably relieve, or avoid, a significant disability that was far beyond what is usual in terms of causing difficulty or an inability to undertake everyday living activities

iii Sir Thomas Bingham MR in *R v Cambridge Health Authority ex p B* [1995]

The second column in the table in Appendix 2 gives an indication of circumstances in which each of the North Central London PCTs, or the North Central London Acute Commissioning Agency acting on their behalf, might consider it appropriate to fund such a treatment, subject always to consideration of all aspects of the prevailing version of the framework of principles to be found in Appendix 1. It is important to note that exceptionality is a 'threshold condition', i.e. a finding of exceptionality does not mean that the PCT responsible for a particular patient is bound to approve funding, but is the start of the process of making a decision in an individual case because the responsible PCT must balance this with the other components of the principles framework. There are two instances in this list where no such examples are given. This is because we are not aware of any robust evidence to support such treatments. However, were such evidence to be made available then, similarly, the responsible PCT be willing to consider a funding request, in the light of such evidence and balanced against all components of the framework of principles, on an individual basis.

3 Clinical effectiveness

The framework of principles (see Appendix 1) defines clinical effectiveness. It would be inappropriate to fund treatments where there was little or no evidence of clinical effectiveness or where that evidence was weak: if we fund one type of treatment where there is poor evidence of clinical effectiveness then we would be obliged to fund all treatments where there was similarly weak evidence of clinical effectiveness. We also consider that the fact that a condition may be rare and thus its treatment may be more difficult to research does not constitute a valid reason for us to accept poor quality evidence.

For some 'low priority' treatments, as far as we know, robust and convincing evidence of clinical effectiveness is lacking, although the responsible PCT would be pleased to review any good evidence that were made available as part of an individual patient treatment funding request. In other instances, there is good evidence of clinical effectiveness of the 'low priority' treatments but this must be balanced with the other principles in the framework including, but not limited to, cost effectiveness, equity and distributive justice.

4 Cost effectiveness

In assessing cost-effectiveness, we have to consider the balance between cost and benefit, whether the benefit is likely to be long-lasting, and whether the precedent of funding one treatment may require us to fund treatments for other conditions (which would also require us to consider affordability, equity and distributive justice issues, among others). The fact that a treatment may be relatively inexpensive does not mean that it is cost-effective if there is poor evidence of its clinical effectiveness. Similarly, if we agree to fund one type of treatment solely because it is inexpensive then we become obliged to fund all treatments that are similarly inexpensive: funding a large number of treatments that are individually inexpensive costs a large amount of money and this would not be available to support the use of other treatments where the evidence of clinical and cost effectiveness (and other considerations) are more convincing, or to address issues of health inequalities, and this would prevent us from using a limited budget to the maximum advantage of the maximum number of people.

5 Affordability

A multi-million pound levy has been placed on most London PCTs for 2009/10 and 2010/11 to provide deficit support for a number of acute hospital trusts. In addition, some North Central London PCTs are over their capitation position. This means that they expect to receive below-average growth in their funding in 2010/11, in addition to any impact that the current national economic situation will have on public sector spending.

Whilst all North Central London PCTs seek to achieve balanced budgets for 2009/10, there are substantial pressures against this which mean that their individual ability to achieve the statutory financial breakeven duty is likely to be compromised.

It is also now apparent that the NHS will not have a budget uplift in 2011/12 and probably for several years thereafter because of the need for the government to address national budget problems. This means that staff pay raises and any increases in costs ('medical inflation' typically runs at 5-10% each year) will have to be managed within a budget that is, effectively, frozen. North Central London PCTs are therefore having to implement savings this year and next to help mitigate this severely adverse situation.

As the resources available to PCTs are finite and they are statutorily required to balance our budget and not to overspend, they also have to take affordability into account when considering what treatments and other clinical interventions they can fund.

6 Equity

There are three components to this. The first is that, within the requirements of legislation and NHS regulations, and other than where there is good evidence that a particular characteristic (e.g. age) or lifestyle (e.g. smoking) adversely impacts the clinical and/or cost-effectiveness of treatment, the North Central London PCTs will not discriminate between people on personal or lifestyle grounds.

The second component is that health care should be allocated justly and fairly on the basis of need, and the North Central London PCTs will seek to maximise the welfare of all the people for whom they are responsible within the resources made available to them. In this context, equity means that people in equal need should have equal access to care. But everything has an opportunity cost; if resources are used for one person then those same resources are not available for someone else. So, if we give resources to one person that are disproportionate to their need or ability to benefit then we deny those resources to others who might benefit more and this would be inequitable.

In the context of an individual patient treatment funding request, PCTs also need to consider, on an individual patient basis, whether there are exceptional circumstances that might be relevant in their case. Our definition of exceptionality is provided in section 4.1 of the framework of principles (see Appendix 1). Section 4.2 of this framework defines limits to this. As noted earlier, exceptionality is a 'threshold condition' and thus any finding of 'exceptionality is the start of the process of making a decision in an individual patient's case because PCTs must balance this with the other components of the principles framework.

7 Quality and safety

PCTs are sometimes asked to fund treatments (which may or may not be considered to be 'low priority' as referred to in this document) in institutions or that are provided by people who are not within the NHS. Whilst there are good mechanisms in place to assure quality and safety in NHS organisations, this is not necessarily the case in other organisations or with individual practitioners and individual PCTs, and/or the North central London Commissioning Agency acting on their behalf, will also need to take into account the evidence for the safety and quality of the proposed treatment when considering any such funding applications.

8 Ethical considerations

8.1 Autonomy

We should respect a patient's capacity to think and decide what they want for themselves, and we recognise an obligation to help people to make such decisions by providing any and all information that they need. We also recognise that we should respect their final decision, even if it is not what we think is best for them. We assume that most patients will wish to try the proposed treatments that we are being asked to fund (although this is not always the case). However, of itself, this does not mean that any individual PCT should fund such requests.

We also need to consider another aspect of autonomy, albeit not strictly the ethical aspect of this: that some treatments may enable a patient to maintain their independence and/or dignity (e.g. prolonging the time that they can continue to perform everyday living activities with relative independence) and we consider that this is a desirable objective, although it will not necessarily take precedence over other considerations. We would need to see good quality evidence that a proposed treatment might reasonably be expected to benefit the patient in this way and this must be balanced against the other components of the principles framework.

8.2 Beneficence

We recognise an obligation of beneficence, which emphasises the moral importance of 'doing good' to others, entailing doing what is 'best' for the patient or group of people, and we recognise that many treatments might be considered to do so, albeit sometimes only to a very limited extent or in special or poorly predictable circumstances (for example, it is not always possible to know that a patient is likely to respond to a treatment in the way that those in a research trial did, especially if there are aspects of their circumstances that might have led them to have been excluded from the trial or trials put forward as evidence for the effectiveness of the proposed treatment).

We also have an obligation to do good to others and our responsibility is for all people registered with North Central London GPs not just for an individual person. We therefore have to balance the impact of doing good for one person with the effect that that would have on our ability to do good for others. In considering this, we also have to recognise that all decisions set precedents: if we agree to fund this request for one person then we become obliged to fund all requests where the circumstances are similar and this would increase the cost and thus the opportunity cost which could impact on our ability to do good for others. Therefore, even where there may be some evidence that a particular treatment or clinical intervention might 'do good' for an individual, this must be balanced against the other components of the principles framework.

8.3 Non-maleficence

We recognise a duty of non-maleficence, which requires that we should seek not to harm people. However, it is important to recognise a distinction between a duty not to harm someone (which implies actively doing something that may harm them) – which we recognise as something we should not do – and not acting to prevent possible harm. We consider that there is an important difference here because it is not possible for us to prevent harm coming to everybody, and therefore we do not consider that there is an obligation for us to fund an intervention just because it might reduce the risk of some sort of harm coming to an individual.

We also need to consider whether the likely risks of a proposed treatment are balanced by its likely benefits. We also recognise that few, if any, treatments are likely to be without side effects or adverse reactions in all patients in all circumstances. Further, we need to take account of whether not funding a treatment might do the patient harm. However, we also have a duty not to harm others and funding a treatment inappropriately could do this, albeit indirectly, by denying them access to treatment that could otherwise do them greater good.

For similar reasons, a treatment of likely limited benefit and/or of relatively high cost will not necessarily be provided simply because it may be the only active treatment available.

8.4 Distributive justice

The principle of distributive justice emphasises two points: patients in similar situations should normally have access to similar health care; and when determining what level of health care should be available for one set of patients, we must take into account the effect of such a use of resources on other patients. In other words, we should try to distribute limited resources (such as time, money, intensive care beds) fairly, and based on need.

Need usually exceeds the resources available. We therefore cannot always enable every patient to have what some might think of as the ‘best possible’ care. This concept conflicts with the principles of some clinicians who, understandably, take the view that every patient should be given the ‘best possible’ care and that every therapeutic option should be tried irrespective of cost. However, if we provide the 'best possible’ care for everyone then at some time during the year there will be nothing left for others: we will be giving some patients 'everything' and others 'nothing'. We consider that such an approach would be inappropriate and that we should share resources 'fairly', this usually meaning (i) giving resources preferentially to those who are in greatest need and who can benefit the most from them, and (ii) settling for what is adequate and not necessarily what may be the ‘absolute best'. We believe that this approach is consistent with the opinion expressed by Sir Thomas Bingham in his judgment in the ‘Child B’ case.[iii]

9 Conclusion

Appendix 2 sets out a non-exhaustive, i.e. an indicative, list of the types of treatments that we consider to be of lower priority for funding than others and therefore that we will not routinely fund. We consider that this is reasonable having taken account of the various components of the framework of principles, and that it is rational in so far as other PCTs have similar lists of ‘low priority’ treatments and similar principles frameworks. By being willing to consider funding requests for such treatments on an individual basis, and to consider the possibility of exceptionality (as defined in the framework of principles) were there is good evidence for this, we believe that this is also a reasonable approach to take for organisations with finite budgets and more calls on that budget than can be accommodated within their statutory obligations.

North Central London Sector
October 2010

Appendix 1: Framework of Principles

This document describes the principles that we have applied in drawing up this 'low priority' treatments policy.

The intent of the North Central London PCTs is to improve the health and well-being of their populations and to ensure that there are good quality, appropriate health promoting and health care services for those people that need them. We wish to ensure that people receive health services that are appropriate for the 21st century.

The experience of the NHS from its inception is that demand has always outstripped supply. There is no evidence that this is changing and thus we must sometimes choose between providing one type of service or treatment over another. The North Central London PCTs are committed to focusing their resources where they are needed most.

The North Central London PCTs are responsible for the health and health care of some 1.24m people registered with local GPs, a population that is expected to grow by some 100,000 over the next few years. We are therefore responsible for the health and health care of a lot of people and the needs of those populations are different in different parts of the North Central London sector. If we spend money or allocate other resources (e.g. staff time) in one area, or for one group of people or for one individual, then those resources cannot be used for someone else. We therefore try to ensure that our resources are used to the benefit of the largest number of people. This inevitably means that it is not always possible for everyone to get exactly what they want or when they want it; we have to prioritise some services and individual treatments over others.

A PCT's decision on an individual patient treatment request[i] does not concern whether it is clinically appropriate for a patient to have the treatment recommended by their clinical adviser, but whether it is appropriate for them to fund it. This responsibility has been recognised in the courts, most notably in the 'Child B' case, when the judge said:

> "I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much the cost, particularly when a life is potentially at stake.
>
> "It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients." [ii]

This observation has been quoted with approval in a number of appeal judgments on individual patient treatment requests since and remains an accurate statement of the law. In another case concerning the funding of an individual treatment,[iii] the court stated that:

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i PCTs receive a number of requests for treatments that are outside service level agreements ('TOSLAs') either because a treatment is specifically excluded from a contract (sometimes by national requirement) or because a patient or their clinician proposes treatment to be provided by an organisation or an individual with whom a PCT does not have a current contractual arrangement. Such requests are dealt with on an individual patient basis

ii Sir Thomas Bingham MR in *R v Cambridge Health Authority ex p B* [1995]

iii *R v NW Lancashire Health Authority, ex parte A, D&G* [1999]

> "…in establishing priorities, comparing the respective needs of patients suffering from different illnesses and determining the respective strengths of their claims for treatment, it is vital for an [NHS funding body] accurately to assess the nature and seriousness of each type of illness; to determine the effectiveness of various forms of treatment for it; and to give proper effect to that assessment and that determination in the application of its policy.
>
> "The [NHS funding body] can legitimately take into account a wide range of considerations, including the proven success or otherwise of the proposed treatment; the seriousness of the condition… and the costs of that treatment".

In this case, the court also stated that:

> "It is natural that each [NHS funding body], in establishing its own priorities, will give greater priority to life-threatening and other grave illnesses than to others obviously less demanding of medical intervention. The precise allocation and weighting of priorities is clearly a matter of judgment for each authority, keeping well in mind its statutory obligations to meet the reasonable requirements of all those within its area for which it is responsible. It makes sense to have a policy for the purpose, indeed, it might well be irrational not to have one. "

In drawing up a policy on 'low priority' treatments, we have therefore applied a number of 'principles', and balanced these against each other, in determining what we should not fund as a matter of routine. These principles are:

1 Clinical effectiveness

Our resources should be used in the most clinically effective way –

- clinical effectiveness is the extent to which specific clinical interventions, when deployed in the field for a particular patient or population, do what they are intended to do – that is, maintain or improve health, and secure the greatest possible health gain from available resources;[1]
- we recognise a distinction between 'evidence of lack of effectiveness' and 'lack of evidence of effectiveness', and we will seek to avoid supporting the use of interventions for which evidence of clinical effectiveness is either absent, or too weak for reasonable conclusions to be reached;
- as well as strength of evidence for a particular intervention, we will also take into account the likely magnitude of benefit and of safety for patients, as well as the number of people who can reasonably be expected to benefit from that intervention;
- when assessing evidence for clinical effectiveness, we will give greater weight to some outcome measures than to others, for example, but not limited to –
  - randomised controlled trials and large observational studies published in peer-reviewed journals are likely to provide more robust evidence for a finding than individual case reports, small case series or anecdote;
  - trials of longer duration and those with clinically relevant outcomes are likely to provide more robust evidence for a finding than those of shorter duration or those with surrogate outcomes,
  - reported levels of 'patient satisfaction' do not necessarily provide good evidence of clinical effectiveness or the likelihood of others having similar outcomes with the same or with similar treatments; and
- we will seek our own expert advice on topics as we may consider necessary.

2 Cost effectiveness

Our resources should be used in the most *cost* effective way –

- the NHS has finite resources and is required to keep within its budget, so to maximize the care that can be given to patients generally we must extract the maximum value from the money we spend and from the way in which all other types of resources are used;
- the cost of treatment is relevant because every activity has opportunity costs – if resources are used in one area they cannot be used in another, so we must seek to use all resources in the most appropriate way if the greatest number of people possible are to benefit in the greatest possible ways; and
- decisions to fund a treatment have the capacity to set a precedent – if one person or a group of people are given treatment then others in similar circumstances will expect to receive the same treatment. Thus, a decision about the treatment of one person or a group of people can have resource implications beyond that individual or group.

3 Affordability

We should only commission the services that we consider are appropriate if we have enough money or other resources to do so –

- we are statutorily required to keep within the resources available to us, that is, we are legally bound not to spend more money each year than we have been allocated; and
- if we use money or other resources on one investment then we cannot use the same resources for another. So we consider that, even if something is clinically effective and it is, compared to other interventions for the same condition, also cost-effective, this does not necessarily mean that we will be able to support its use because we may not always have enough money or other resources available or because other investments are determined to be of a higher priority.

4 Equity

Our resources should be used in an equitable way –

- within the requirements of legislation and NHS regulations, and other than where there is good evidence that a particular characteristic (e.g. age) or lifestyle (e.g. smoking) effects the clinical and/or cost-effectiveness of treatment, we will seek not to directly or indirectly discriminate between people on the grounds of[iv] –
  - age
  - gender
  - ethnicity
  - physical, sensory or learning disability
  - religious beliefs
  - sexual orientation
  - place of abode[v]
  - employment
  - financial status
  - personal lifestyle
  - social position or status;
  - suggested 'individual worth', e.g. having a particular occupation or being a parent or carer

iv This list is not exhaustive, but is intended to provide examples of the types of differences between people that the we will not use as grounds for determining whether one person or group of people should or should not receive a particular treatment, other than where there is good evidence that a characteristic is associated with poorer or better clinical or cost-effectiveness

v Other than the fact that PCTs are only responsible for the health care needs of the residents of their boroughs, for people registered with their general medical practitioners, for the provision of a range of school nursing services to children attending their local schools, and for visitors to their areas who develop a need of emergency health care whilst there

- health care should be allocated justly and fairly on the basis of clinical need, and we will seek to maximise the welfare of the largest possible number of people within the resources available to us. However, we will be willing to be flexible so that variations from this approach may (but will not necessarily always will) be made in certain circumstances, such as (but not necessarily limited to) –
  - treatment that may be 'life-saving' in acute circumstances,[vi]
  - treatment for those whose quality of life is extremely severely affected by disabling chronic condition,[vii]
  - special characteristics of an individual patient justifying treatment of higher cost than normal, e.g. where an intervention may be less cost-effective for a particular person because of a disability or other characteristic but would normally be available under the NHS and funded by this PCT to others who did not have that disability or other characteristic.

4.1 Commissioning services or treatments in individual cases

PCTs commission care for patients suffering from various clinical conditions. Care pathways are usually agreed at the beginning of the financial year as part of a PCT's budget setting process. This means that clinicians and service users can know what medical treatments they can expect and which treatments are not funded by a PCT. PCTs get better value for money by commissioning in this way. However PCTs accept that there may be individual cases where their established commissioning policies have not taken account of the particular circumstances of an individual. The North Central London PCTs are prepared to consider commissioning treatment for such individuals who can demonstrate that they have exceptional circumstances. The onus of proving exceptionality is on the patient and on the clinical team supporting the application.

If a patient or their clinician seek to show that they are 'exceptional', this will be considered on an individual basis and in comparison within the group of patients with the same clinical condition. Generally, we will consider two components to exceptionality (although the presence of one or both factors to some degree may not be sufficient to lead to a decision by a PCT that the case is exceptional) –

1. the clinical circumstances of the patient may be exceptional. For example there may be good evidence that they may reasonably be expected to respond much better than others with the same condition to the proposed treatment and they may be highly unusual in not being able tolerate the treatment usually provided for a patient with their clinical condition;
2. The patient may have exceptional personal circumstances, but these would normally need to be 'far beyond what is usual' in order to be exceptional. For example, being a carer for an elderly relative or having dependent or disabled children is unlikely to be considered in this way as it would not be 'far beyond what is usual'.

It might be possible for a patient to prove that they are exceptional because they suffer from a condition for which there is no established care pathway or no established treatment which is routinely provided.

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vi This exception does not include treatment that may prolong life or slow disease progression, rather, it refers to treatment that could be required immediately to significantly reduce the chance of someone dying within minutes or hours of the sudden onset of a life-threatening situation.

vii Such disability would be far beyond what is common, for example, it might include someone who is paralysed below the neck and dependent upon nursing care for all of their bodily functions. but it is unlikely to include someone who is disabled but who has no significant difficulty in undertaking everyday living activities

If a treatment for a condition has been considered for funding as part of the PCT's annual process and has not been approved for funding, it is not open to a patient to seek to make a case for funding for that treatment solely or substantially on the basis that they suffer from the condition or suffer from symptoms which are usually associated with that condition.

Funding will only be approved on an individual basis for exceptional patients where the proposed treatment for which funding is sought is both proved to be likely to be clinically effective and is proved to be cost effective, and subject to consideration of the other principles in this framework. For example the fact that a patient may:

- have a rare (or 'orphan') condition, does not mean that –
  - their proposed treatment should be funded simply because their condition is rare. It would be inequitable to preferentially fund those with uncommon conditions over those with more common ones,
  - we will accept a lower standard of evidence of clinical effectiveness or a different level of cost-effectiveness or other consideration in comparison with that which we would consider for people with more common conditions,
  - we will accept that the treatment, because the rareness of the condition, need necessarily be more expensive, especially as many governments grant various allowances and dispensations to manufacturers of orphan drugs to compensate for the smaller market available for their products;
- be suffering from a rare condition, does not necessarily mean that their symptoms are rare and thus require special treatment, for example for the management of pain;
- have a clinical picture that matches the accepted indications for a treatment that is not routinely funded does not, in itself, constitute exceptional circumstances. Hence, for example, a patient may not be able to tolerate the usual treatment for a chronic condition due to side effects which occur in a proportion of patients with that condition. The fact that the patient is in that cohort is highly unlikely to make the case exceptional so as to justify treatment options which are not made available to other patients;
- have already received a treatment (however this may have been funded, including by other NHS organisations) and/or to be deemed in some way to have already responded to treatment does not, in itself, constitute an exceptional circumstance or mean that they should automatically receive funding by a PCT for further such treatment or related treatment;[viii, ix]

The presence of one or more such potentially 'exceptional' factors may not be sufficient to justify a PCT agreeing to shift resources to support the requested investment as PCTs have to balance that request with all the principles in this framework.

We also take the view that whilst we will broadly follow a system for assessing clinical and cost-effectiveness and take affordability, equity and other factors into consideration, especially where a treatment is of extremely high cost, whether or not it is for a rare condition, we will not make an exception just because the condition is rare or is a more common condition which, for a particular patient, has manifested itself in some way which makes the condition difficult to treat.

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viii We consider that it would be inequitable to fund in such circumstances alone and that such funding requests should be considered individually against the principles in this framework

ix Related to this, we will not reimburse costs or fees that patients or their family or friends or others may have incurred in their choosing to undergo investigation or treatment outside the NHS

4.2 A limit to the consideration of individual cases:

Whilst we will be willing to consider possible exceptionality in making individual patient treatment and population-based service funding decisions, if we consider that there is no realistic possibility of a treatment or a service being proved to be clinically effective, cost-effective, affordable, equitable to fund, or reasonable to fund on other grounds, we will not normally be prepared to look at the case as an individual one based on alleged exceptionality. However, we will be willing to consider an individual case if there is compelling evidence that the anticipated cost of the proposed treatment in that individual case is significantly less than the anticipated cost of treating other patients with the same condition who could benefit from the same proposed treatment, or if there is compelling evidence that the outcome for an individual patient is very likely to be significantly and beneficially greater. We will also be willing to keep a 'no exceptions' policy on any such treatment or service under review and be willing to reconsider our general approach to commissioning such treatment in the light of new and compelling evidence.

Similarly, it may be that, in some circumstances, a PCT will not fund treatment for a particular condition, even if the condition is medically recognised as an illness requiring intervention categorised as medical and/or curative, rather than merely cosmetic or a matter of convenience or lifestyle, but we may – as appropriate – consider some treatments as service developments and deal with them en bloc by tender or as part of a service level agreement negotiation with a provider rather than as an individual patient treatment request.

Further, whilst we consider that people should generally be able to access health and health care services on the basis of equal need, we note that –

- there may be occasions or circumstances when some categories of care or specific interventions will be given priority in order to help address health inequalities in the community;
- health and health care services should be allocated justly and fairly on the basis of both need and capacity to benefit, in order to maximise benefits to the population within the resources available. However, in the absence of evidence of health need or reasonable capacity to benefit, treatment will not generally be given solely because an individual person or a group of people request it. Similarly, a treatment of likely limited benefit and/or of relatively high cost will not necessarily be provided simply because it may be the only active treatment available;
- sometimes the needs of the wider population conflict with the needs of individuals, especially when an expensive treatment may possibly produce some clinical benefit but only for a relatively limited time. For example, such a treatment may do something to improve a patient's (or group of patients') condition to some extent or slow the progression of disease but not change the ultimate outcome, i.e. it will not 'cure'. However, more people may gain greater benefit if the same money or other resources were used for other purposes, even if that may not be in the best interests of an individual or smaller group of people; and
- we cannot always enable every patient to have what some might think of as the 'best possible' care. This concept conflicts with the principles of some clinicians who, understandably, take the view that every patient should be given the 'best possible' care and that every therapeutic option should be tried irrespective of cost.[x] However, if we provide the 'best possible' care for everyone then at some

[x] Whilst clinicians have a direct legal duty of care to their patients, NHS funding bodies only have a 'target duty' (i.e. 'something to be aimed for') and are not legally required under sections 1 and 3 of the National Health Service Act 2006 to provide the 'best' or 'most expensive' treatment available

time during the year there is likely to be nothing left for others: we will be giving some patients 'everything' and others 'nothing'. We consider that this would be inappropriate and that we should share resources fairly, this usually meaning (i) giving resources preferentially to those who are in greatest need and who can benefit the most from them, and (ii) settling for what is adequate and not necessarily for what may be the 'absolute best'.

5 Quality and safety

The services we commission should be safe and of high quality to minimise risk to people and to minimise waste –

- high quality care can be thought of in terms of doing the right thing, in the right way, to the right person, at the right time and doing it right first time; and
- failing to do this risks harming people and wasting finite resources (and thus harming other people by denying them access to services that can no longer be afforded).

Thus, we will need to be satisfied that any service provider has adequate quality and safety mechanisms in place. Generally, these will have to be equivalent to NHS governance mechanisms, and we will expect all standards set by the relevant health and social care standards bodies to be met in full.

6 Ethics

The approach that we take to determining health and health care priorities should take account of ethical considerations, specifically[2] –

- *respect for personal autonomy* – which requires that we help people to make their own decisions (e.g. by providing important information), and respect those decisions (even when we may believe that a patient's or a group of people's decision may be inappropriate), noting that this does not require us to fund a specific treatment just because someone wants it, but only if it satisfactorily meets sufficient other criteria in this framework and that this does not require us to fund a treatment in a particular place other than as the patient may be entitled to under the requirements of the national 'Patient Choice' initiative or other NHS regulations;

  and, we recognise that some treatments may enable a patient to maintain their independence and/or dignity, e.g. prolonging the time that they can continue to perform everyday living activities with relative independence, and we consider that this is a desirable objective, although it will not take precedence over other considerations in this framework;
- *beneficence* – which emphasises the moral importance of 'doing good' to others, entailing doing what is 'best' for the patient or group of people,[xi] although this will not take precedence over other considerations in this framework and must be balanced with an equal obligation for us to seek to 'do good' for all of the people in the population for which we are responsible;
- *non-maleficence* – which requires that we should seek not to harm patients, and, because most treatments carry some risk of doing some harm as well as good, the potential goods and harms and their probabilities must be weighed to decide

xi The question of who should be the judge of what is 'best' is often interpreted as focusing on what an objective assessment by a relevant health professional would determine as in the patient's best interests, with the patient's own views being considered through the principle of respect for patient autonomy, the two only conflicting when a competent patient chooses a course of action that might be thought of as not in their best interests

what, overall, is in a patient's or group of patients' best interests. We will also consider whether not funding a particular treatment or service might 'do harm', but it must also be noted that we have a duty of non-maleficence to others – we could indirectly harm others because a decision to fund treatment for one person or group of people could prevent others from receiving other care of proven clinical and cost-effectiveness, so this consideration in the context of an individual treatment or service will not take precedence over other considerations in this framework; and

- *distributive justice* – which recognises that time and resources do not allow every patient to have the 'best possible' treatment and that decisions must be made about which treatments can be offered within a health care system. This principle of justice emphasises two points:
  - people in similar situations should normally have access to similar health care, and
  - when determining what level of health care should be available for one group, we must take into account the effect of such a use of resources on others (i.e. the opportunity costs).

7 General principles

In determining which treatment priorities to focus on, we will use mechanisms that –

- *follow technology appraisal guidelines (TAGs) from the National Institute for Health and Clinical Excellence (NICE)* where they exist and where the circumstances of patients meet NICE TAG criteria precisely and in full;
- *are based on good quality evidence* – using both local data (to enable effective targeting) and the results of high-quality research, including systematic literature reviews in peer-reviewed publications, and including clinical guidance from national health-professional bodies (to enable us to support care that is appropriate for the largest number of people possible);
- *are transparent*, i.e. the reasoning behind our decisions made should be clear and available to anyone who wishes to see them (as long as patient confidentiality is preserved);
- *are ethical*, i.e. that meet principles of fairness and appropriateness and that seek to provide the greatest good for the greatest number of people whilst not discriminating against people who, because of their personal circumstances (e.g. a disability) would benefit from treatment provided in a less cost-effective way than were their circumstances otherwise to be similar to those of others with the same condition; and
- *are managerially robust*, i.e. that follow due process and can be seen to have done so.

8 Accountability

We will be accountable for our decisions, through –

- *publicity* – decisions and their rationale will be publicly accessible, i.e. the processes and the principles behind them will be 'transparent',
- *reasonableness* – our decisions and their rationale should reflect an 'even-handed' and 'sensible' interpretation of how we should ensure both value for money and equitable access to the services that we commission for the varied health needs of the population, within the resources available to us;
- *an appeal process* – there may be objections from individuals or from groups to decisions made on recommendations made by a PCT and these will be dealt with

by the PCT responsible for the individual patient using their own appeal and/or complaints mechanisms; and

- *enforcement* – there will be regulation of these processes by the PCT to ensure that these various conditions are met.

9 Ensuring probity

People involved in making decisions using this framework will be bound by the 'Seven Principles of Public Life' defined by the Nolan Committee. These are:

- **selflessness** – holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends;
- **integrity** – holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.;
- **objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.;
- **accountability** – holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office;
- **openness** – holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands;
- **honesty** – holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest; and
- **leadership** – holders of public office should promote and support these principles by leadership and example.

10 Developing this framework

The principles described in this document will be developed:

- in the light of our experience and that of other organisations, especially to ensure a fair and ethical approach;
- in response to new scientific evidence coming to light concerning the effectiveness of health and health care interventions;
- as public values and perceptions change; and in response to changes in legislation and regulatory requirements.

REFERENCES

1 NHS Executive. *Promoting Clinical Effectiveness: a framework for action throughout the NHS*. Department of Health, 1996

2 Parker M, Hope T. Ways of thinking about medical ethics. In *Ethics*. The Medical Publishing Company Ltd. 2000

Appendix 2: A list of 'low priority' treatments that will not be funded routinely but only on consideration of individual patient circumstances, i.e. on a 'prior approval' basis

Treatment that will not be routinely funded	Potential exceptions, but subject to consideration on an individual patient basis and in the context of all of the criteria in the framework of principles in this document	Comment
Ventilation tube (grommet) insertion for otitis media with effusion (glue ear)	Children between the ages of 3 and 12 years at the time of the proposed treatment who have otitis media with effusion (OME) where: ■ there has been a period of at least three months watchful waiting from the date of the first appointment with an audiologist or GP with special interest in ENT **AND** the child is placed on a waiting list for the procedure at the end of this period, **AND** ■ OME persists after three months **AND** the child suffers from at least one of the following: • at least 5 recurrences of acute otitis media in a year • evidenced delay in speech development • educational or behavioural problems attributable to persistent hearing impairment together with a hearing loss of at least 25dB particularly in the lower tones (low frequency loss) • a significant second disability, e.g. Down syndrome, when, in addition to the above age criterion, where there is OME, a proposal to insert grommets is made by the multi-disciplinary team managing the patient and they agree that (i) hearing aids have been tried and failed or are considered to be wholly inappropriate, (ii) this is a practical proposition with a very low likelihood of extrusion. For children with cleft palate, in addition to the above	■ the evidence of effectiveness is limited ■ surgery may resolve glue ear and improve hearing in the short term compared with non-surgical treatment, but there is less certainty about long-term outcomes and large variation in effect between children ■ a Cochrane review showed that the benefits of grommets in children is small compared with myringotomy or non-surgical treatment.[a] The effect of grommets on hearing diminished during the first year. It recommended an initial period of watchful waiting for most children with OME. ■ there continues to be debate about how best to select children for surgery and there is a high rate of spontaneous resolution of glue ear, particularly in younger children ■ the Scottish Intercollegiate Guidelines Network (SIGN) recommend that children under three years of age with persistent bilateral otitis media with effusion and hearing loss of =<25 dB but no speech and language, development or behavioural problems can be safely managed with watchful waiting.[b] If watchful waiting is being considered, the child should undergo audiometry to exclude a more serious degree of hearing loss.

a Cochrane review: Grommets for hearing loss associated with otitis media with effusion. January 2005

b SIGN. Diagnosis and management of childhood otitis media in primary care. February 2003

	age criterion, a proposal to insert grommets is made by the multi-disciplinary team managing the patient and they agree that (i) hearing aids have been tried and failed or are considered to be wholly inappropriate, (ii) grommet insertion is to be undertaken at the time of primary closure of the cleft palate NOTE: the insertion of ventilation tubes is not considered to be a low priority treatment when the procedure is a key component of of another procedure such as repairing the tympanic membrane.	Children with persistent bilateral otitis media with effusion who are over three years of age or who have speech and language, developmental or behavioural problems should be referred to an otolaryngologist.
Tonsillectomy and adenoidectomy (separately or in combination)	■ In children, where there is significant severe impact on quality of life indicated by at least seven episodes of tonsillitis in the preceding year, or five episodes/year in each of the preceding two years, or three episodes/year in the preceding three years, and documented evidence of absence from school or attendance at GP or other health care setting. [c] ■ obstructive sleep apnoea confirmed by overnight oxygen saturation monitoring ■ In adults with proven recurrent group A streptococcal pharyngitis (GAHSP)[d] ■ Quinsy associated with tonsillitis, requiring 2 or more hospital visits ■ Patients with tonsillar enlargement causing upper airway obstruction	■ A revised Cochrane systematic review in 2008,[e] concluded that Adeno-/tonsillectomy is effective in reducing the number of episodes of sore throat and days with sore throats in children, the gain being more marked in those most severely affected. ■ SIGN national guideline on management of sore throat and indications for tonsillectomy published April 2010 recommended watchful waiting is more appropriate than tonsillectomy for children with mild sore throats. ■ It should be noted, that those considering tonsillectomy or adenotonsillectomy for themselves or their children, and those advising them, should be aware of two important uncertainties which may affect their treatment decisions. They must acknowledge some uncertainty about whether or not their symptoms

[c] Adapted from Management of sore throat and indications for tonsillectomy. A national clinical guideline. SIGN Publication Number 117. April 2010

[d] Tonsillectomy versus watchful waiting in recurrent streptococcal pharyngitis in adults: Randomised controlled trial. BMJ 2007;334(7600):939-41..

[e] Burton MJ, Glasziou PP. Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis. Cochrane Database of Systematic Reviews 2009, Issue 1. Art. No.: CD001802. DOI: 10.1002/14651858.CD001802.pub2.

		are primarily due to their tonsils and realise that adeno-/tonsillectomy is not a panacea for all types of sore throat. There is also uncertainty about the likelihood that these will continue in the future, which is only partly predictable from the frequency and severity of symptoms they have experienced in the past. ■ Grommets and adenoidectomy represents a trade off between benefits and harms; adenoidectomy on its own is of unknown effectiveness[f]
Cochlear implants	Normally, Cochlear implants will only be funded where the patient meets the criteria of the National Institute for Health and Clinical Excellence technology appraisal guideline on this treatment precisely and in full and then only if the least expensive implant available is used assuming that this is clinically appropriate	A cochlear implant in one ear is recommended as a possible option for everyone with severe to profound deafness if they do not get enough benefit from hearing aids after trying them for 3 months. Cochlear implants in both ears are recommended for the following groups with severe to profound deafness only if they do not get enough benefit from hearing aids after trying them for 3 months and the implants are placed during the same operation: ■ children ■ adults who are blind or have other disabilities which mean that they depend upon hearing sounds for spatial awareness. In all cases, if more than one type of cochlear implant is suitable, the least expensive should be used.
Varicose veins, reticular veins, telangectasia	■ substantial skin changes including varicose eczema, lipodermatosclerosis, moderate to severe oedema; ■ intractable ulceration secondary to venous stasis; ■ bleeding from a varicosity that has eroded the skin or they	■ symptoms attributable to varicose veins are common but their relationship to visible trunk varices is not clear[g]

f Clinical Evidence. Review of adenotonsillectomy. 2005

g Bradbury A, Evans C, Allan P et al. What are the symptoms of varicose veins? Edinburgh vein study cross sectional population survey. *Br Med J* 1999;318:353-356

	have bled and are at risk of bleeding again; or ■ recurrent phlebitis (more than one documented episode) ■ severe and persistent pain and swelling interfering with activities of daily living and requiring chronic pain management ■ severe symptoms attributable to the venous disease not acceptably relieved by 6 months documented conservative management including compression hosiery and exercise	■ most patients with varicose veins are never harmed by them and good explanation and reassurance are fundamental.[h] ■ the National Institute for Health and Clinical Excellence has published detailed guidance on what treatment should be considered for varicose veins and when[i] ■ treatment for reticular veins and telangectasia is generally considered to be cosmetic (see section on cosmetic surgery)
Dental implants	■ major loss of tissue as a result of trauma or cancer surgery ■ significant congenital abnormalities, such as cleft lip and palate and hypodontia, where the abnormality or the process of correcting it, make it impossible for other prostheses to be used ■ significant neuromuscular disorders and other conditions (e.g. Parkinson's Disease, Bell's palsy), which make it impossible for patients to manage conventional dentures ■ some oral mucosal conditions, e.g. Sjogren's syndrome ■ severe jaw atrophy or alveolar bone resorption making retention of conventional dentures impossible	Primary predictors of implant failure are poor bone quality, chronic periodontitis, systemic diseases, smoking, unresolved caries or infection, advanced age, implant location, short implants, acentric loading, an inadequate number of implants, and absence/loss of implant integration with hard and soft tissues. Inappropriate prosthesis design also may contribute to implant failure[j,k] Implant treatment for patients who have undergone irradiation to the maxilla and/or mandible has a significantly higher failure rate.[k] Patients who are over 60 years of age, smoke, have a history of diabetes or head and neck radiation, or are postmenopausal and on hormone replacement therapy experience significantly increased implant failure compared with healthy patients.[k]
Surgical treatment of carpal tunnel syndrome	■ symptoms persisting after conservative therapy with local corticosteroid injection and/or nocturnal splinting ■ significant neurological deficit present, e.g. sensory	

h Campbell B. Clinical Review- Varicose veins and their management. BMJ 2006;333:287-292 (5 August)

i NICE 2001. Referral Advice: A guide to appropriate referral from general to specialist services.http://www.nice.org.uk/nicemedia/pdf/Referraladvice.pdf

j Porter JA, von Fraunhofer JA. Gen Dent. 2005 Nov-Dec; 53(6):423-32

k Moy PK, Medina D, Shetty V, Aghaloo TL. Int J Oral Maxillofacial Implants. 2005 Jul-Aug; 20(4):569-77

	blunting, muscle wasting, or weakness of thenar abduction ■ severe symptoms that significantly interfere with everyday living activities	
Hysterectomy for menorrhagia (heavy menstrual bleeding)	■ documented medical contra-indication to Minera® coil insertion when other treatments have failed or are contraindicated ■ severe anaemia, unresponsive to transfusion or other treatment whilst a Mirena trial is in progress ■ recent sexually transmitted infection (if not fully investigated and treated) ■ distorted or small uterine cavity (with proven ultrasound measurements) ■ genital malignancy ■ active trophoblastic disease	NICE has published clinical guidelines on menorrhagia which do not necessarily require a prior trial of treatment before hysterectomy. These guidelines include recommendations on the use of other procedures, currently covered by NICE interventional procedures guidance, which should be considered in the context of a patient pathway for managing menorrhagia
Cosmetic surgery, including minor skin surgery	■ suspicion of malignancy ■ significant adverse effect on activities of daily living ■ significant disfigurement ■ major weight loss leaving significantly excessive skin folds ■ severe, post-pubertal gynaecomastia ■ congenital facial anomalies ■ significant post-surgical or radiotherapy deformity ■ following severe trauma ■ These conditions, which might cause skin hypopigmentation are not considered to be a low priority • mycosis fungoides • lymphoma • sarcoidosis • regressed menaloma • genital lichen sclerosis • tuberose sclerosis • leprosy	This includes (but is not limited to) – – abdominoplasty – breast reduction/augmentation – face lifts and similar facial surgery, including blepharoplasty – acne treatment other than with drugs – skin flap excision, e.g. after substantial weight loss – pinnaplasty – removal or obliteration of benign skin lesions including, but not limited to – • benign pigmented moles • comedones • corn/callouses • lipomas • milia • molluscum contagiosum • sebaceous, epidermoid or pilar cysts • seborrhoeic keratoses

		• basal cell papillomas • skin tags (including anal tags) • spider naevae and other telangiectasia • warts • xanthelasma • neurofibromata • rosacea – rhinoplasty – treatment of skin hypopigmentation (this exclusion includes conditions such as vitiligo but not those listed in the second column) treatment of erythema for cosmetic purposes – surgical treatment of rhinophyma – skin resurfacing – botulinum toxin or other treatment for the appearance of skin-ageing – scar revision or excision (including keloid scarring) – liposuction and other surgical treatments of excess fatty tissue or contouring (e.g. buttock lift) – male pattern baldness treatment – hair removal or obliteration for hirsuitism – tattoo removal – cosmetic genital surgery
Wisdom tooth (third molar) removal	■ unrestorable caries ■ non-treatable pulp and/or periapical pathology ■ cellulitis ■ abscess and osteomyelitis	See NICE guidance[l]

l http://www.nice.org.uk/nicemedia/pdf/wisdomteethguidance.pdf (accessed 8 February 2010)

	■ fracture of tooth, ■ internal / external resorption of the tooth or adjacent teeth ■ disease of follicle including cyst / tumour ■ tooth/teeth impeding surgery or reconstructive jaw surgery ■ when a tooth is involved in or within the field of tumour resection ■ plaque formation and pericoronitis depending on severity and frequency of episodes.	
Male circumcision and other genital surgery for cosmetic or non significant functional problems	■ scarring of the opening of the foreskin making it non-retractable (i.e. pathological phimosis). This is unusual before 5 years of age ■ recurrent, significantly troublesome episodes of infection beneath the foreskin ■ restoration of functional anatomy after female circumcision to facilitate childbirth where mutilation renders this hazardous	Female circumcision is prohibited by under the Prohibition of Female Circumcision Act 1995
Ganglions	■ significant pain or dysfunction unrelieved by aspiration or injection ■ in patients presenting with significant skin breakdown, significant nail deformity, or repeated episodes of drainage caused by distal interphalangeal joint mucous cysts ■ diagnostic uncertainty	
Dupuytren's contracture	■ function of hand is significantly impeded or deformity is significantly disabling so that everyday living activities cannot be undertaken and surgery is likely to resolve this	
Trigger finger	■ the patient has failed to respond to conservative measures (e.g. hydrocortisone injections); or ■ the patient has significant fixed deformity	A Cochrane review has shown that corticosteroid injections can be effective for the treatment of trigger finger, but evidence is limited by being based on two small studies in secondary care, and there were only data available for effectiveness of up to four months. The authors concluded that the initial treatment for patients should be corticosteroid injection rather than

		surgery, and other non-invasive interventions such as splinting may also be appropriate first-line interventions.[m]
Bartholin's cysts	■ significant infection and/or rapid growth causing significant pain that is unresolved by non-surgical treatment	
Hyperhidrosis	■ significant focal hyperhidrosis and a 1–2 month trial of aluminium salts (under primary care supervision to ensure compliance) has been unsuccessful in controlling the condition ■ intolerance of topical aluminium salts despite reduced frequency of application and use of topical 1% hydrocortisone	
Dilatation and curettage for heavy menstrual bleeding in women aged under 40 years		There is no evidence that this procedure has any therapeutic value
Surgical treatment of chronic sinusitis	■ suspected complications, e.g. periorbital infection ■ suspected sinonasal tumour ■ ENT referral may be appropriate if there is: – recurrent or chronic sinusitis of uncertain cause – unremitting or progressive facial pain – a trial of intranasal corticosteroids for three months has been ineffective – a significant anatomical abnormality	NHS Clinical Knowledge Summaries advise a trial of intranasal corticosteroids for 3 months for treatment in the first instance.[n] Sinus puncture and irrigation has a poor diagnostic yield, and carries the risk of secondary contamination.[n] Only short-term benefit seen in patient refractory to medical management treated with balloon catheter dilation of sinus ostia.[o]

m Peters-Veluthamaningal C, van der Windt DAWM, Winters JC, Meyboom- de Jong B. Corticosteroid injection for trigger finger in adults. *Cochrane Database of Systematic Reviews* 2009, Issue 1. Art. No.: CD005617. DOI: 10.1002/14651858.CD005617.pub2.

n http://www.cks.nhs.uk/sinusitis/management/quick_answers#-369973 (accessed 8 February 2010)

o NICE Balloon catheter dilation of paranasal sinus ostia for chronic sinusitis. IPG 273 NICE September 2008.

Temporo-mandibular joint (TMJ) dysfunction		There is little evidence available on the safety and efficacy of surgery for this condition. Conservative therapy includes self care practices e.g. eating soft foods, jaw stretching, ice packs, and pain relief. Stabilisation splints (bite guards) are the most widely used treatments for TMJ disorders. Failure to respond to conservative treatment is not an indication to proceed to irreversible treatments such as TMJ replacement. There is limited evidence of effectiveness and no agreed diagnostic classification scheme for TMJ replacement
Minor oral surgery for retained roots	Symptomatic retained roots may be removed in the dental surgery under local anaesthetic. Referral to a specialist may be necessary : ■ where anatomical or pathology considerations make the extraction difficult, ■ where the patient has medical complications, ■ where the operator does not have the relevant training or experience, or ■ where previous attempts at extraction have failed	GDC guidelines indicate that 'particular care must be taken when referring patients for treatment under general anaesthesia or sedation' It is also in line with minor oral surgery management and referral guidelines: A Handbook for PCTs and Primary Care Professionals.[p]
Varicocoele	■ persistent discomfort or pain despite adequate conservative management	There is no evidence that treating varicocoele can help male sub-fertility problems
Refashioning scars	■ following severe burns or severe trauma and/or where there is a significant difficulty in undertaking everyday living activities, including severe psychosocial problems following facial scarring	
Complementary medicine of all types	■ there is some evidence that some forms of complementary treatments can be effective in certain conditions	

p Minor oral surgery management and referral guidelines: A Handbook for PCTs and Primary Care Professionals, Sue Gregory, 2006

Reversal of sterilisation	■ extreme personal circumstances, e.g. establishing a stable relationship with a new partner following the death of the patient's partner and all children when there are no children living with the patient and their new partner	Most studies are retrospective and success rate variable.[q] The Royal College of Obstetricians and Gynaecologists guidelines on male and female sterilisation advise that men and women requesting sterilisation should understand that the procedure is intended to be permanent, they should be given information about the success rates associated with reversal, should this procedure be necessary.[r]
Treatment of ME/chronic fatigue syndrome outside NHS service level agreements		No evidence has been forthcoming from units purporting to specialise in this condition to support claims of treatment success. Clinical guidance from the National Institute for Health and Clinical Excellence provides information for health care providers on how this condition could be managed, but do not place any obligation on service commissioners[s]
Implantable cardiac defibrillators	Funding will be made available for patients who meet the criteria of the NICE technology appraisal guideline on the use of implantable cardiac defibrillators precisely and in full[t]	This NICE technology appraisal guideline appraisal does not cover the use of implantable defibrillators for non-ischaemic dilated cardiomyopathy.

q Yossry M, Aboulghar M, D'Angelo A, Gillett W. In vitro fertilisation versus tubal reanastomosis (sterilisation reversal) for subfertility after tubal sterilisation. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.: CD004144. DOI: 10.1002/14651858.CD004144.pub2.

r Royal College of Obstetricians and Gynaecologists (RCOG). Male and female sterilisation. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2004 Jan. 114 p.

s http://www.nice.org.uk/nicemedia/pdf/CG53FullGuidance.pdf (accessed 8 February 2010)

t http://www.nice.org.uk/nicemedia/pdf/TA095guidance.pdf (accessed 8 February 2010)

Knee washout for osteoarthritis	Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking i.e (not gelling, 'giving way' or X-ray evidence of loose bodies)	NICE issued full guidance to the NHS on Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis in August 2007.[u] Subsequent to this, a more specific recommendation was made as part of the the clinical guideline on osteoarthritis published in February 2008 on the indication for which arthroscopic lavage and debridement is judged to be clinically and cost-effective[v]
Apicectomy	• Presence of periradicular disease, with or without symptoms in a root filled tooth, where non surgical root canal re-treatment cannot be undertaken or has failed, or where conventional re-treatment may be detrimental to the retention of the tooth. For example, obliterated root canals, small teeth with full coverage restorations where conventional access may jeopardise the underlying core. It is recognised that non-surgical root canal treatment is the treatment of choice in most cases • Presence of periradicular disease in a tooth where iatrogenic or developmental anomalies prevent non surgical root canal treatment being undertaken • Where a biopsy of periradicular tissue is required • Where visualisation of the periradicular tissues and tooth root is required when perforation, root	The Faculty of Dental Surgery of the Royal College of Surgeons has published guidelines outlining the indications for surgical endodontics[w] Literature shows that the success rate of apical surgery on molar teeth is low and should not be routinely undertaken[x]

[u] National Institute for Health and Clinical Excellence - Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis - Guidance issue date: 22 August 2007. http://www.nice.org.uk/IPG230

[v] National Institute for Health & Clinical Excellence (NICE), Clinical guideline CG59 The care and management of patients with Osteoarthritis, February 2008 www.nice.org.uk/cg59.

	crack or fracture is suspected • Where procedures are required that require either tooth sectioning or root amputation • Where it may not be expedient to undertake prolonged non surgical root canal re-treatment because of patient considerations	
Unilateral bone anchored hearing aids for unilateral deafness (implanted one side) Bilateral bone anchored hearing aids (implanted both sides)	Unilateral bone anchored hearing aids for unilateral deafness : Severe unilateral conductive deafness in children • case by case basis centred on the child's audiometric data, development and communication needs[y] • a trial period with a sufficiently powerful bone anchored hearing aid on a headband is recommended before a decision on implantation	Bone anchored hearing aids are only appropriate for patients with conductive or mixed deafness for whom air conduction hearing aids are ineffective or inappropriate. Comprehensive patient assessment and a trial of bone conductor technology as well as extensive counselling are all essential before the implantation of bone anchored hearing aids. There is evidence for the clinical effectiveness of unilateral bone anchored hearing aids in selected groups of patients. The evidence base for use of bilateral bone anchored hearing aids is weak.

[w] Royal College of Surgeons of England. Guidelines for surgical endodontics. RCS 2001 http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/surg_end_guideline.pdf (Accessed October, 2010)

[x] Molar apicectomy with amalgam root-end filling: results of a prospective study in two district general hospitals. Wesson CM. Gale TM. British Dental Journal. 195(12):707-14; discussion 698, 2003 Dec 20

[y] Bone anchored hearing aids for children and young people: Guidelines for professionals working with deaf children and young people: Guidelines for professionals. National Deaf Childrens Society. March 2010

Autologous Cartilage Implantation (ACI)	If conservative treatment and arthroscopic treatment has failed and is part of a clinical trial in accordance with NICE technology appraisal recommendations	ACI has been most commonly used as a treatment for cartilage defects in the knee, there are few studies of its use in other joints. NICE concluded ACI is not recommended for treating knee problems caused by damaged articular cartilage, unless it is used in studies that are designed to produce good-quality information about the results of the procedure. These results should include measuring any improvement in patients' quality of life, and the benefits and risks of ACI over a long period of time. If ACI is offered as part of a clinical study, the doctor should explain that there are uncertainties about the long-term benefits of this procedure and the possible risks, such as locking of the knee, infections and not being able to fully straighten the leg.[z] There is insufficient evidence to support use of ACI in ankle joint cartilage defects. [aa,bb]

[z] NICE Technology appraisal TA089, May 2008 http://guidance.nice.org.uk/TA89

[aa] Whittaker P et al. Early results of autologous chondrocyte implantation in the talus. *J Bone Joint Surg Br* 2005; 87-B: 179-83. Available at: http://www.jbjs.org.uk/cgi/reprint/87B/2/179?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=whittaker&fulltext=chondrocytes&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT

[bb] Regence. [online]. *Autologous chondrocyte transplantation.* Medical policy no. 87. 2009. Available at http://blue.regence.com/trgmedpol/surgery/sur87.html [Accessed 17 October 2010]

Injections for non-specific back pain		• NICE CG88 (2009) guideline states injections of therapeutic substances should not be used for non specific low back pain [cc] • An updated Cochrane review[dd] concluded there was insufficient evidence to support or refute the use of injections for subacute and chronic low back pain without radicular pain
Spinal Fusion for chronic low back pain	Fusion surgery for chronic low back pain may be considered if: • severe pain continues despite an 'active rehabilitation programme' (cognitive intervention combined with exercises is recommended when available) that has been undertaken for 2 years[ee],[ff]	NICE guidelines recommend the patient is referred to a specialist spinal surgical service if spinal fusion is being considered and to give due consideration to the possible risks for that patient.

[cc] NICE CG88 (2009) – Low Back Pain http://www.nice.org.uk/nicemedia/pdf/CG88NICEGuideline.pdf

[dd] Staal JB,de Bie RA,de Vet HC,Hildebrandt J,Nelemans P: Injection therapy for subacute and chronic low back pain: an updated Cochrane review. Spine, Jan 2009, vol./is. 34/1(49-59), 0362-2436;1528-1159 (2009 Jan 1)

[ee] Airaksinen O, Brox JL, Cedraschi C, Hildebrandt J, Klaber-Moffett J, Kovacs F, Mannion AF, Reis S, Staal JB, Ursin H and Zanoli G. European Guidelines for the Management of Chronic Non-Specific Low Back Pain. November 2004, Amended June 2005. On behalf of the COST B13 Working Group on Guidelines for Chronic Low Back Pain.

[ff] Brox J et al. Four-year follow-up of surgical versus non-surgical therapy for chronic low back pain. Ann Rheum Dis. 2009

Spinal cord stimulation	Spinal cord stimulation will be considered as a treatment option for adults with chronic pain of neuropathic origin who: • continue to experience chronic pain (measuring at least 50 mm on a 0–100 mm visual analogue scale) for at least 6 months despite appropriate conventional medical management, and • who have had a successful trial of stimulation as part of the assessment by a multidisciplinary team experienced in chronic pain assessment and management of people with spinal cord stimulation devices, including experience in the provision of ongoing monitoring and support of the person assessed.	• NICE Technology appraisal TA159[gg] • Spinal cord stimulation is not recommended as a treatment option for adults with chronic pain of ischaemic origin except in the context of research as part of a clinical trial
Surgical discectomy (standard or micro), percutaneous discectomy, coblation therapy and laser discectomy for lumbar disc herniation	Surgical discectomy (standard or micro) will be considered for a carefully selected group of patients with • symptoms and confirmatory signs of lumbar radiculopathy • disc herniation confirmed on magnetic resonance imaging at a corresponding level and side to the symptoms • who have not responded to conservative treatment for over 6 weeks[hh] [ii]	Surgical discectomy for carefully selected patients with sciatica due to a prolapsed lumbar disc appears to provide faster relief from the acute attack than non-surgical management. However, any positive or negative effects on the lifetime natural history of the underlying disc disease are unclear[jj] At present, unless or until better scientific evidence is available, automated percutaneous discectomy, coblation therapy and laser discectomy should be regarded as research techniques[jj]

[gg] NICE Technology Appraisal TA159 - Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin. Issue date October 2008. http://www.nice.org.uk/nicemedia/live/12082/42367/42367.pdf

[hh] Weber H. Lumbar disc herniation. A controlled, prospective study with ten years of observation. Spine 1983 8(2): 131-40

[ii] Weinstein JN, Torteson TD, Lurie JD et al. Surgical vs Nonoperative Treatment for Lumbar Disk Herniation. JAMA 2006 296

Surgery for snoring • laser-assisted uvulopalatoplasty (LAUP) • uvulopalatopharyngoplasty (up3) • radiofrequency ablation of soft palate (RFA)		Evidence of objective reductions in snoring sound parameters for UP3, LAUP, RFA and Pillar implants was limited and equivocal. [kk] NICE recommends that RFA should not be used without special arrangements for audit, consent and research.[ll] In the management of primary snoring it should be highlighted that, given the absence of risk to health from snoring without apnoea or hypopnoea, and an absence of excessive daytime sleepiness, the patient is effectively being treated to decrease the social disturbance caused to their bed partner and family
Caesarean section for non clinical reasons		There is a close benefit/risk ratio for caesarean section for non clinical reasons. Caesarean section rates are progressively rising in many parts of the world. One suggested reason is increasing requests by women for caesarean section in the absence of clear medical indications. There is no evidence from randomised controlled trials, upon which to base any practice recommendations regarding planned caesarean section for non-medical reasons at term[mm]. Maternal request is not on its own an indication

[jj] Gibson JA, Waddell G. Surgical interventions for lumbar disc prolapse. Cochrane Database of Systematic Reviews 2007, Issue 2

[kk] Main C, Liu Z, Welch K, Weiner G, Jones SQ, Stein K. Surgical procedures and non-surgical devices for the management of non-apnoeic snoring: a systematic review of clinical effects and associated treatment costs. *Health Technol Assess* 2009;**13**(3).
[ll] Radio frequency ablation of the soft palate for snoring. IPG124. National institute for Health and Clinical Excellence. May 2005.
[mm] Lavender T, Hofmeyr GJ, Neilson JP, Kingdon C, Gyte GML. Caesarean section for non-medical reasons at term (Review). The Cochrane Collaboration 2009, Issue 3. Available at http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD004660/pdf_fs.html [Accessed 30th September 2010]

		for CS and specific reasons for the request should be explored, discussed and recorded. When a woman requests a CS in the absence of an identifiable reason, the overall benefits and risks of CS compared with vaginal birth should be discussed and recorded[nn]

[nn] National Institute for Health and Clinical Excellence. Caesarean section (CG13). London: NICE; April 2004. Available at: http://guidance.nice.org.uk/CG13 [Accessed 30th September 2010]

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Treatment
Injections for back pain
Surgery for snoring
Knee washout for osteoarthritis
Apiectomy
Spinal Fusion for low back pain
Surgical discectomy, percutaneous discectomy, coblation therapy and laser discectomy for lumbar disc herniation
Bone Anchored Hearing Aids
Grand Total

2010/11 M7 YTD Low Priority treatment by PCT

BARNET		CAMDEN		ENFIELD		HARING
Activity	Cost	Activity	Cost	Activity	Cost	Activity
351	£353,490	120	£132,538	454	£439,897	178
113	£101,612	60	£50,805	53	£45,023	56
27	£41,111	14	£24,242	17	£34,247	24
26	£21,854	2	£1,700	25	£20,992	30
2	£16,852	1	£10,215	2	£16,275	
1	£3,899	1	£5,792			3
3	£7,132			2	£4,652	
523	**£545,950**	**198**	**£225,292**	**553**	**£561,086**	**291**

GEY	ISLINGTON			
Cost	Activity	Cost	Total Activity	Total Cost
£170,307	107	£109,203	1210	£1,205,435
£51,577	65	£67,020	347	£316,037
£61,618	4	£7,831	86	£169,049
£24,064	3	£2,550	86	£71,160
			5	£43,342
£13,868	3	£13,497	8	£37,056
	3	£6,427	8	£18,211
£321,434	**185**	**£206,528**	**1,750**	**£1,860,290**

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Appendix 3: Equality and Diversity Impact Assessment

1. Policy or Function Title	Low Priority Treatments extended policy		
2. Purpose of the Function/Policy	This policy includes additional procedures that have been added to the existing proscribed Low Priority Treatments policy, implemented from 1st September 2010.		
3. Name of Person Carrying out Assessment	Lynda McDonald/Programme Manager	**4. Date**	14th December 2011

5. Evidence for assessment of the current arrangements (attach to form)	The Low Priority Treatments (LPTs) extended policy includes a number of additional procedures. NCL activity data has been obtained for each additional treatment listed in the LPTs extended policy, this detail is attached as Appendix 4. Assessment of this data shows that the implementation of this policy will impact on a small number of people across the sector, approximately 2,997 in a full year, and that there will be no differential negative impact.		
☐	UK Census data (London, Borough, or National)	**6. Does the evidence show that this policy/function is likely to have a differential negative impact?**	
☒	NCL data	☒	**No** – If "No", Stop the assessment
☐	Other Trust research/audit/survey data Describe data... Describe data... Describe data... Describe data...	☒ ☒ ☒ ☒ ☒ ☒	**No** – Race/Ethnicity **No** – Disability **No** – Sex/Gender **No** – Religion/Belief **No** – Sexual Orientation **No** – Age If **"Yes",** continue with the form
☐	Other External research/audit/survey data Describe data... Describe data... Describe data... Describe data...	**7. Can any differences be justified?**	
		☐	**Yes/No**– If Yes, complete the description below, then Stop the assessment Describe the justification, i.e." Positive Action Initiative" etc...
☐	Other evidence Describe evidence... Describe evidence... Describe evidence...	**8. What is the expected level of impact?**	
		☐	**Low** – If low, Stop the assessment
		☐	**High** – If High, continue with the form

9. Proposed Actions
List the actions required for correcting the negative impact, including dates and lead manager...
10. Consultation It is expected that patients/public, among others, should be involved in any consultation
List details of consultation on actions...
11. Monitoring Monitor and review evidence to confirm that planned actions do actually result in changes/improvements sought for relevant under-represented or disadvantaged groups
Describe monitor and review process...
12. Other Comments/Notes
Enter any other comments/notes if applicable...

THE NHS IN NORTH CENTRAL LONDON	**BOROUGHS:** All **WARDS:** ALL

REPORT TITLE: NHS North Central London (NCL) Update

REPORT OF:
Stephen Conroy Director of Communications and Engagement, NHS North central London
Senior Responsible Officer QIPP, NHS North Central London.

FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE: 21st January 2011**

SUMMARY OF REPORT:

This report provides an update on NHS North Central London work in response to enquiries by JHOSC members.

Financial update
Management cost savings
Borough budgets
GP commissioning
BEH Clinical Strategy

CONTACT OFFICER:
Stephen Conroy
Director of Communications and Engagement, NHS North Central London
Tel 0203 317 6243 stephen.conroy@islingtonpct.nhs.uk

RECOMMENDATIONS:
Members are asked to note the report.

SIGNED:

Stephen Conroy
NHS North Central London
DATE: 14 January 2011

NHS North Central London (NCL) Update

Financial Update 2010/11

The underlying position for the NCL PCTs for 2010/11 is projected to be in the region of £100M. This includes some historic deficit and in year problems – notably Haringey at £30M. Camden and Islington remain in balance for 2010/11. NCL has received some support from NHSL and the Challenge Trust Board and has in place a series of mitigating actions.

At month eight, NCL is showing a deficit position of £25M. Further mitigation is in place and the revised year-end target agreed with NHS L is to finish at £35M over budget.

A full financial report is going to the NCL Board 20th January.

PCT Budgets

PCTs remain as statutory bodies until they are abolished in 2013 and each has a capitation budget and need to plan to deliver a balanced budget. If PCTs are overspend at the year end, then there is a Challenge Trust Board mechanism in London to help PCTs subject to a rigorous process and clear plans to deliver a balanced budget – it cannot be an on-going option to manage PCT deficits.

Management cost savings

The PCTs are required to make management cost savings of 54% by March 2011. A formal 90 consultation is underway and due to finish 21st February. A voluntary redundancy scheme is in place. It is anticipated that the new organisational structure will be in place by 1st April.

GP commissioning development

All 5 GP consortia in NCL are applying for Pathfinder Status by March 2011. These are conterminous with boroughs, although acute commissioning will remain at the NCL level for the time being. Assuming they are successful, they will received £2 per registered population to develop GP commissioning from 1st April 2011. Pathfinders must demonstrate the support of local GPs, contribute to delivering the QIPP and they may take on delegated budgets.

BEH Clinical Strategy

NHS London is currently assessing the review of the BEH CS against the four reconfiguration criteria set out in the revised operating framework 2010/11. This will go to the NHS L Board on 26th January.

New Chief Executive at NCL

Caroline Taylor, currently CEO at NHS Croydon and head of London Specialist Commissioning, will take up her post shortly.